DOCUMENT RESUME

ED 295 072 CG 020 812

AUTHOR Warren, Constancia
TITLE Improving Student's Access to Health Care: School-Based Health Clinics. A Briefing Paper for Policymakers.
INSTITUTION Center for Public Advocacy Research, New York, NY.
SPONS AGENCY Ford Foundation, New York, N.Y.; New York Community Trust, N.Y.
PUB DATE Oct 87
NOTE 86p.
PUB TYPE Reports - Descriptive (141)

EDRS PRICE MF01/PC04 Plus Postage.
DESCRIPTORS *Clinics; *Elementary Schools; Elementary Secondary Education; *Health Facilities; *Health Needs; School Activities; *Secondary Schools; *State Programs
IDENTIFIERS New York; *School Based Health Clinics

ABSTRACT

This document discusses school-based health clinics and the valuable role they can play in meeting the health care needs of children. The barriers that prevent thousands of New York State's children from getting adequate preventive and primary care are discussed. The first chapter details key components of the basic comprehensive school-based health clinic model: location, target population, staffing, range of services, administrative structure, provider relationship, and community relationship. The second chapter describes circumstances that converge to limit children's access to adequate primary and preventive health care in New York State. The third chapter discusses New York State's experience with school-based health clinics, describing first those health services mandated under state education law. The fourth chapter recommends that New York State expand its school-based clinic initiative, beginning by establishing a state-level planning process that would include representation from government and from providers and advocates concerned with school health issues. The fifth and final chapter sets forth a strategy for funding school-based health clinics, recommending that the legislature commit funds for creating clinics in the state's highest-risk schools. (ABL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

CG

ED295072

IMPROVING STUDENT'S ACCESS TO HEALTH CARE: SCHOOL-BASED HEALTH CLINICS

A Briefing Paper for Policymakers

by

Constancia Warren, Ph.D.

CG 020812

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Ronald Soloway

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

for the

CENTER FOR PUBLIC ADVOCACY RESEARCH, INC.

BEST COPY AVAILABLE

The Center for Public Advocacy Research, Inc. is a non-profit organization committed to identifying important public policy issues, conducting research as a basis for informed action, and advocating sound policy development on issues affecting those who are economically disadvantaged and politically disenfranchised.

This report was made possible by support from the Ford Foundation and the New York Community Trust (Eleanor Robson Belmont Fund, William and Francoise Barstow Foundation, and Emilie D. Robb Fund).

Copies of this report may be obtained from the Center for $10.00 each.

Center for Public Advocacy Research, Inc.
12 West 37th Street
New York, New York 10018
(212) 564-9220

Ronald Soloway
Executive Director

Copyright 1987 by the Center for Public Advocacy Research, Inc. All rights reserved. Printed in the U.S.A.

IMPROVING STUDENTS' ACCESS TO HEALTH CARE: SCHOOL-BASED HEALTH CLINICS

A Briefing Paper for Policymakers

by

Constancia Warren, Ph.D.

Center for Public Advocacy Research, Inc.
12 West 37 Street
New York, New York 10018
(212) 564-9220

Ronald Soloway
Executive Director

October 1987

Table of Contents

Acknowledgements i

Executive Summary and Recommendations 1

1. School-Based Health Clinics: The Basic Model 7

2. New York's Children Have Limited Access to Health Care 15

- Economic Constraints 16
- Age-Related Constraints 24
- Geographic Constraints 30
- Constraints Imposed by Changing Family and Work Patterns 32
- Summary 33

3. School-Based Health Clinics in New York State 37

- Some Historical Background 37
- New York State School Health Laws 39
- New York State's School Health Demonstration Program 41
- New York City's Clinic Controversy 44

4. Implementing School-Based Health Clinics 47

- Key Implementation Issues 50
  - Target Population 50
  - Location 52
  - Staff 53
  - Range of Services 54
  - Administrative Structure 56
  - Provider Relationship 56
  - Community Relationship 57
  - Evaluation 58

5. Funding School-Based Health Clinics in New York State 61

- General Funding Strategy 62
- The School Health Demonstration Program 63
- Medicaid 64
- Local Matching Funds 71
- Other Federal and State Funds 71
  - Federal Funds 73
  - State Funding Sources 75
  - Funding for Health-Related Activities in School 77

References 81

Acknowledgements

I have enjoyed the advantage of many people's advice, experience, information, and support throughout the preparation of this report. From early suggestions on how to approach the task to the careful review of the first draft, my work has been enriched by the commitment and generosity of my colleagues.

Barry Ensminger wisely advised me to view controversy as an ally in the effort to expand New York State's School Health Demonstration Program, providing excellent tips on where to begin the research and advocacy. Sharon Lovick of the Support Center for School-Based Clinics, Kay Johnson of the Children's Defense Fund and Jody Levin-Epstein of the Center for Population Options helped explain the complexities of Medicaid funding as it relates to school-based clinics. Judy Cohen of the American Academy of Pediatrics shared valuable information on several different aspects of Medicaid policy and its impact on children and youth in New York State. John Rodat explained the growing problem of the uninsured population in New York State and offered helpful suggestions on what measures could be tapped to locate concentrations of medically indigent children.

I am grateful to Joyce Hughes and Ned Smith from the New York State Department of Health, whose availability and cooperation made both the research and advocacy much easier and, I am certain, more successful. Naomi Marsh provided, in addition to incredible energy and enthusiasm, valuable information and insights into school health policy and legislative policymaking.

Alice Radosh and Alwyn Cohall both helped shape my understanding of the special health needs of adolescents and the advantages of school-based health clinics in addressing those needs. Maxine Golub of the Bronx Committee for the Community's Health was always supportive and helpful, sharing both written materials and anecdotal information that gave insight into the "street-level" implementation and funding problems faced by existing clinics.

Michelle Cahill, Joy Dryfoos, Elizabeth McGee, Sylvia Pirani, Sid Socolar, and Robin Willner all strengthened my research with their advice, information, and feedback on the work in progress, as did many others who generously answered questions and shared information along the way.

I am indebted to my colleages at the Center for Public Advocacy Research for their support and encouragement as I struggled with a new area of policy, for sharing my enthusiasm, and for their careful editing of this report. Betsy Andrews contributed typing and editing skills, in addition to frequent assistance in tracking down new sources of information.

Finally, I wish to thank Anne Warren for carefully editing both drafts for grammar and clarity, and Bruce Dollar, who, in addition to proofreading the final draft, has managed to support and endure the production of yet another report.

Executive Summary and Recommendations

This briefing paper is about school-based health clinics and the valuable role they can play in meeting the health care needs of children. It is also about the barriers that prevent thousands of New York State's children from getting adequate preventive and primary care, and how school-based clinics can help overcome these obstacles. It is directed primarily to state policy makers and legislators, as well as health, education, and social service advocates, but should also be of interest to those concerned with child health and adolescent pregnancy issues, and to the members of the media who cover these issues. We hope that this paper will serve as the basis for a state initiative to expand the number of school-based health clinics in medically underserved areas of New York State.

Chapter 1, **School-Based Health Clinics: The Basic Model**, details the key components of the basic comprehensive school-based clinic model: location, target population, staffing, range of services, administrative structure, provider relationship, and community relationship. These design elements yield substantial advantages in meeting the preventive and primary health care needs of school-age children. In particular, the placement of health care services in a location where students who use it spend most of their time facilitates case-management of care, which in turn plays a critical and positive role in delivering both better quality and more efficient health care.

Chapter 2, **New York's Children Have Limited Access to Health Care**, describes the four sets of circumstances that converge to limit children's access to adequate primary and preventive health care in New York State.

1) Economic constraints severely restrict access for thousands of children to the basic health care services more affluent families take for granted.

Medicaid eligibility levels are too low and discriminate against larger families. Despite a 29% increase in the number of children and families in poverty between 1980 and 1984, 87,000 fewer children were covered by Medicaid in 1984 than in 1980.

Medicaid's preventive care program, the Child/Teen Health Plan, fails to reach thousands of enrolled children. Less than 5% of the enrolled school-age children received screening exams in 1986.

An increasing number of New Yorkers lack health insurance or have inadequate coverage. Between 1980 and 1984, the number of uninsured rose by 454,000. More than half of these people were employed. Those without health insurance or with inadequate coverage are less likely to receive preventive care, and are more likely than those with health insurance to rely on expensive and often publicly funded institutional providers when they do get care.

2) Age-specific constraints render all adolescents both a "hard-to-reach" and a high-risk population group.

Adolescents are the only population group for whom morbidity rates have increased in the last two decades.

Adolescents have **different** health care needs than young children or adults; they more frequently suffer from health problems associated with risk-taking behavior, alcohol and drug abuse, sexually transmitted diseases, and adolescent pregnancy.

Adolescents face several obstacles in obtaining health care that often prevent them from seeking care in a timely manner:

- o even inexpensive services are beyond their economic means;
- o many health care facilities are not open when adolescents are not in school; and
- o relatively few pediatricians or family practitioners are adequately trained in the specific issues of adolescent medicine.

3) Geographic constraints in New York State's rural areas prevent many rural school students from getting adequate preventive and primary health care:

Rural New Yorkers are less healthy in general than their metropolitan counterparts, and have less access to health care professionals, especially those serving low-income patients:

- o in addition to a general scarcity of health care providers in

rural areas, many of these doctors limit the number of Medicaid patients they see, or do not accept Medicaid patients at all;

- hospital closings and consolidations in recent years have reduced the number of institutional health care providers in rural areas; and

- fewer than one-quarter of the hospitals in rural areas have outpatient departments where poor and low-income patients can receive care.

4) Constraints imposed by changing family and work patterns have made it increasingly difficult for many parents to make time for preventive health care visits for their children.

Because of these obstacles, too many of New York State's children and youth are not getting the health care services they need to grow up healthy and to take advantage of the opportunities offered to them.

Chapter 3, **School-Based Health Clinics in New York State,** discusses New York State's experience with school-based health clinics, describing first those health services mandated under state education law. The School Health Demonstration Project, initiated in 1981 to provide preventive and primary health care services in districts where substantial numbers of students lacked access to adequate health care, has, to date, resulted in the creation of more than one hundred clinics at the pre-school, elementary school, junior high and middle school and high school levels, funded by a combination of state legislative appropriation and federal monies. Still more clinics are badly needed in the more than one thousand of the state's 3,902 schools that have significant concentrations of medically indigent students.

These clinics, which have been evaluated extensively, have brought valuable preventive and primary health care services to thousands of students, detecting numerous previously untreated medical problems, and

earning the overwhelming support for the clinics from parents, teachers and administrators. Despite the controversy surrounding the high school clinics initiated by the School Health Demonstration Program in 1985, a recent evaluation study showed similar parental support for the high school clinics as well.

Chapter 4, **Implementing School-Based Health Clinics**, recommends that New York State expand its school-based clinic initiative, beginning by establishing a state-level planning process that would include representation from government and from providers and advocates concerned with school health issues. It then makes specific implementation recommendations:

Target population: measures that indicate both community health needs and the availability of health care resources should be used to determine where new clinics should be located.

Location: clinics should be located either within or adjacent to schools (rather than in nearby facilities), according to the particular health health care needs of the host community.

Staffing: the core clinic team should consist of a supervising pediatrician or family practitioner (with training and experience specific to the age of the student population), a mid-level practitioner, a health aide, and a psychologist or a social worker, working closely with health personnel already in the school.

Range of services: clinics should provide preventive and primary health care services, as well as health promotion and education; and that reproductive health care services be either directly provided or easily accessible in clinics serving adolescents.

Administrative structure: clinics should be run by professional health care or multiservice facilities, rather than by schools, except in rural districts lacking adequate alternatives.

Provider relationship: selection of health facilities to staff and run the clinics should place primary emphasis on the provider's willingness and capacity to implement a holistic approach to dealing with the health care needs of students, consistent with the range of services that should be offered.

Community relationship: clinics should develop and maintain close working relationships with their host communities.

Evaluation: the expanded School Health Demonstration Program should be evaluated over the course of at least three years, assessing baseline conditions in high-risk districts, the process of establishing clinics, and the impact of the clinics on the lives of the students and schools they serve.

Chapter 5, **Funding School-Based Clinics in New York State**, sets forth a strategy for funding school-based health clinics, recommending that **the legislature should commit $14 million in new funds over the next three years to create clinics in half of the State's highest-risk schools.** The state funds would serve as the core funding for clinics, supplemented with federal and state resources (described in this chapter), as well as local and private support. In addition, the chapter details the particular problems current providers have experienced with Medicaid reimbursement, which has provided far less support for clinic activities than originally expected, recommending state action to:

raise medicaid eligibility levels to 100% of the federal poverty standard for all individuals and families, thus providing coverage for the 34% of New York State's children living in families with incomes below the poverty level who are now excluded from coverage;

create and fund a mechanism in the clinics for establishing eligibility and enrolling students in the Medicaid program if they are eligible but not currently enrolled;

provide reimbursement for a broader range of preventive care services offered by the clinics;

establish higher reimbursement rates for the clinic to cover the real cost of providing service;

create an earmarked pool of Medicaid funding to support innovative outreach initiatives that will to increase utilization of the Child/Teen Health Plan, including school-based health clinics; and

better coordinate the multiple streams of funding that supporting health and health-related activities.

Chapter 1

School-Based Health Clinics: The Basic Model

School-based health clinics have the threefold goal of 1) establishing a service delivery mechanism for meeting the primary and preventive health care needs of school-age children in a comprehensive and continuous manner, 2) forging a partnership of health education and promotion with medical care and treatment, and 3) through this partnership, promoting the effective use of primary and preventive care among families who have not had the opportunity to establish these practices with their own resources.

Seven key design features enable clinics to meet these goals: location, target population, staffing, range of services, administrative structure, relationship to back-up providers, and relationship to the host community.

location

target population

staffing

Although there are many variations on the basic model, a school-based health clinic generally is a unit located either within or adjacent to a school that provides comprehensive preventive and primary care to medically underserved children. In the most prevalent model, piloted and replicated by the Robert Wood Johnson Foundation, nurse practitioners, always with the supervision of physicians (and often in partnership with psychologists, social workers, health educators and/or health aides), "immunize, give physical examinations and make diagnoses, treat minor injuries, manage most common childhood illnesses and identify in

children more serious clinical problems that require care by physicians, dentists, or other health professionals." [1] In addition, clinic personnel work with students, both individually and in groups, to educate them about how best to promote their own health and how to make most effective use of the health care resources available to them.

range of services

Although clinics are located within a school or on school grounds, almost all school-based clinics are organizationally external to the school system, administered by local health care facilities (hospitals, community health centers) or not-for-profit social services organizations. These back-up providers often provide other non-medical services as well. Many schools, in addition to providing space for the clinic, also provide supplies, maintenance services and clerical support.

administrative structure

In the overwhelming majority of cases, the clinic is an outstationed facility of the back-up provider, rather than a free-standing health facility. This external organizational base is a critical factor in meeting the program's goals of providing comprehensive primary care even when the school building is closed (evenings, weekends, vacation

provider relationship

---

1. Robert Wood Johnson Foundation, "Special Report," Number One, 1979, p. 7.

periods). It also provides the mechanism for securing more specialized medical services if a student's problem warrants such care.

community relationship

Finally, whether they emerged from community groups organizing to meet the health care needs of their children or were initiated by health providers concerned about the inadequacy of existing primary health care facilities, all successful school-based health clinics have established and maintained strong community relationships. They have advisory boards that include parents and community members; some clinics also offer a range of health education services to parents and community members, thus strengthening relationships with the community and promoting better health practices in students' families.

These characteristics yield substantial advantages for providing high-quality comprehensive and continuing primary care to the students they serve. School-based clinics are easily accessible--both physically and psychologically--so students may be seen at their convenience, without the loss of school days for them or work days for their parents. This accessibility is particularly important for such preventive care measures as complete physical examinations, which children from poor families rarely receive. Minor injuries and illnesses often can be treated immediately and on site, guaranteeing prompt attention and avoiding major disruption in the students' class schedules.

> Janine is an honor student in a New York City high school. She suffers from severe chronic asthma. Before a clinic was established in her high school she had to leave school when she had an asthma attack, traveling for an hour to reach home. She often missed school, as many as fifty-four days in a single school year. Now she simply reports to the clinic in her school, where she is given medication that allows her to return to class the following period.[2]

Students, in turn, are more accessible to clinic staff when the clinic is within a school, facilitating follow-up and enabling staff to contact students and to assure appropriate supervision of their care.

Because the clinic serves only the student population of the host school, the health care offered is more likely to be age-appropriate than in an outpatient department of a hospital or a community health center that serves all ages. Clinic staff are specially selected for their experience and ability to deal with children or adolescents; indeed, some clinic staff have sought these positions because of their interest in a particular age group. This specialization is particularly important when treating adolescents, whose emotional and psychosocial problems produce the bulk of their visits to existing health clinics, and whose needs are too often indadequately understood by pediatricians who focus on younger children.

Finally, the care provided by the clinic's medical team can be holistic, drawing on multifaceted staff to ensure a full response to a child's problem, usually in a single location. In addition to both medical and psychosocial treatment, clinic staff are able to educate students about how to care for themselves, whether in response to particular conditions, or simply to promote and maintain better health.

---

2. This case and the two that follow are drawn from "Speakout on School-based Health Clinics: Impact on Students' Lives," New York City, June 9, 1987. (Students' names have been changed to protect their privacy.)

> Linda is seventeen. She often feels tired, and the whites of her eyes are slightly yellow. Although she is not sure that she is really sick, she finally talks to the doctor about her problem. The clinic refers Linda for tests; the results show that she has sickle cell anemia. After teaching Linda how to care for herself, the clinic staff give her materials to read on sickle cell anemia, promising to give her a quiz the following week to be certain that she has understood the information. Several weeks later, the social worker asks Linda to talk about how she feels about having a chronic illness, and helps her come to terms emotionally with her problem.

In infrequent cases, school-based health clinics call upon the back-up facility to provide specialized care to an individual student. When this is necessary, the relationship between the clinic and the back-up provider facilitates the process of referral (making appointments, transferring records) and follow-up.

> Bob is an avid athlete, so he first ignores a pain in his lower abdomen. After a few days, however, the pain is so severe that he tells his physical education teacher, who takes him to the school clinic. After examining Bob, clinic staff call an ambulance to take him to the hospital that runs the clinic, where he is given emergency surgery just in time to avoid a ruptured appendix.

Community support for the school-based clinic can provide a base for activities that address the particular health needs of the host community. It can also help develop a grass-roots constituency for the clinic program; in the case of one foundation-supported demonstration project, this led to the assumption of funding from local tax-levy sources.

Clinic personnel also can provide continuity of primary care services over time rather than the patchwork of services at various clinics and/or emergency rooms that is more likely to characterize the health utilization practices of the poor. A study of the health care utilization patterns of low-income mothers found, for example, that 40 percent of the mothers used

multiple and different providers for both well and sick care for their children, while 22 percent had no source or used only the emergency room for both well and sick care.[3]

The most important advantage of the school-based clinic over the kind of medical care that children from poor families most often receive is in the area of coordination and case-management. The greatly increased accessibility of students in the school setting permits clinic personnel to carry out the intensive follow-up work that is difficult to implement in other settings, and that is essential to effective case-management.

The value of the case-management and continuity of care made possible by the school-based clinic model cannot be overemphasized. Research on children's access to health care stresses that "[E]quality of access involves not just patterns of health care utilization but also the nature and quality of the services received." The critical qualitative factor is a regular medical provider who can manage most or all aspects of a patient's care.

> A regular primary care doctor should, in theory, deliver appropriate preventive care, monitor health status, coordinate a patient's specialty medical services, and in general provide more effective care because of the knowledge and trust built up over time . . .[4]

---

3. Adapted from the report of the U.S.DHEW, "Child Health Care - EPSDT and MCH: a Service Delivery Assessment, November 1979, Appendix III, in D. D. Dutton, "Children's Health Care: The Myth of Equal Access," in Better Health For Our Children: A National Strategy, report of the Select Panel for the Promotion of Child Health to the U.S. Congress and the Secretary of Health and Human Services, Volume IV, pp. 382-383.

4. D. D. Dutton, op.cit., pp. 375-376.

In a study of pediatric clinics organized to provide both coordination and continuity of care, researchers found that children using the clinics' services had "fewer hospitalizations, operations, illness visits, and unkept appointments, . . . more preventive visits, and lower costs."[5] Unfortunately, most poor families depend on multiple health care providers, with many seeking medical care only in emergencies. Ironically, this not only leads to less effective medical care but also to less efficient care as well.

Many of New York State's school-age children do not have access to adequate preventive and primary health care, much less the quality of care that can be provided in comprehensive school-based health clinics. The next chapter will discuss the primary barriers that prevent thousands of children from receiving the care they need, as well as the effectiveness of the school-based clinic in overcoming these obstacles.

---

5. J. J. Alpert, L. A. Robertson, J. Kosa, M. C. Heagarty, and R. J. Haggerty, "Delivery of Health Care for Children: Report of an Experiment," Pediatrics, Volume 57, pp. 917-930, 1976, in D. D. Dutton, op. cit., pp. 382-385.

Chapter 2

New York's Children Have Limited Access to Health Care

In New York State, four sets of circumstances converge to limit children's access to primary preventive health care services: 1) economic constraints that threaten to make routine preventive care a luxury in an increasing number of households; 2) problems associated with adolescence, both as health problems per se and as constraints on the appropriate and timely use of medical services; 3) service gaps in rural health care systems, particularly in areas already affected by poverty and unemployment, and 4) the increasing labor-force participation of women and the resulting change in the management of children's health care needs. School-based health clinics have proved to be, both in New York State and elsewhere, an excellent mechanism for overcoming these access barriers.

According to the 1986 Proposed Health Plan for New York State, 42.4% of the state's 3,695,702 school-age children (5-19 years old) are medically indigent, living in poor families with incomes at or below 185% of the federal poverty level.[1] These are the families most likely to have inadequate insurance policies or no health insurance of any kind.

Poor children seek medical care less frequently than more affluent children (despite higher levels of disability), and the care they receive when they do seek treatment often is fragmented and unsystematic. These disparities are particularly noticeable with regard to preventive care,

---

1. "Proposed State Health Plan, 1986," New York Statewide Health Coordinating Council and New York State Department of Health, Division of Planning, Policy and Resource Development, Volume I, p. 164, Data from the New York State Department of Health, Vital Statistics, 1984.

where the consequences of undetected and untreated problems can be especially serious.[2]

> Most of the severe health problems affecting women and children today . . . are often not isolated events, but are incidents that create life-long anguish and suffering for the individuals, families and communities involved. The combined financial and emotional costs to society are great and the comprehensive treatment remedies are often complex and expensive. **Both health care and societal costs could be greatly reduced by the implementation of effective preventive strategies.** Preventive services can be strengthened with additional resources and an increased recognition of the value of prevention as an essential and primary component of the health care system.[3] (Emphasis added.)

But preventive care frequently is not fully reimbursable (if at all) under less-than-generous health insurance policies. In addition "well-child and health promotions services for the Medicaid-eligible population and the poor . . . are not widely available in either the upstate or downstate regions."[4] For these children's families, preventive health care is often "deferred in the face of more immediate needs," leading to "more costly emergency room visits for childhood illnesses" or "epidemics of nearly eradicated diseases in areas where immunization levels are low."[5]

Economic Constraints

In New York State, restrictions on Medicaid eligibility and deep changes in the structure of the labor market have left an increasing number of children with inadequate access to health services.

---

2. D. D. Dutton, "Children's Health Care: The Myth of Equal Access," in Better Health For Our Children: A National Strategy, Report of the Select Panel for the Promotion of Child Health, Vol. IV, 1981, pp. 365-368.

3. "Proposed State Health Plan," pp. 179-180.

4. Ibid., p. 191.

5. Ibid., p. 191.

Medicaid eligibility levels are too low, especially for larger families. Under current New York State regulations, the income levels used to determine eligibility for Medicaid discriminate against larger families. A family of three people qualifies for Medicaid if the household income is 80% of the federal poverty level, but an income of more than 67% of the federal poverty standard will disqualify a family of four; income more than 51% of the federal poverty standard will render a family of six ineligible for Medicaid.[6] Despite an increase of 29% in the number of children and families in poverty in New York State between 1980 and 1984, 102,000 fewer New Yorkers were covered by Medicaid in 1984 than had been so in 1980.[7,8] More than 87,000 of those "squeezed" out by New York State's Medicaid eligibility standards were children.[9] In fact, by 1985, 34% of children living in families with incomes below the federal poverty level in New York State were not covered by Medicaid.[10]

In addition, many pediatricians limit their practices with regard to Medicaid patients, treating only emergency cases, referrals from another doctor, former private patients, or a predetermined percentage of their

---

6. "COUNTERBUDGET '88: A Blueprint for Fairness and Equity," Statewide Emergency Network for Social and Economic Security (SENSES), February 1987, p. 23.

7. "New York's Poor: A Growing Problem," a SENSES Counterbudget Report, prepared by Signalhealth, January 1987, p. 3.

8. "New Yorkers are Losing Their Health Insurance," prepared for SENSES by Signalhealth, March, 1986, p. 6.

9. M. A. McManus and S. M. Davidson, "The Role Of Public Health Insurance For Children," McManus Health Policy Associates, Draft report, Table 14A.

10. M. B. Sulvetta and K. Swartz, "The Uninsured and Uncompensated Care: A Chartbook," p. 9., chart adapted from The Data Book: The Nation, States and Cities, 1985, p. 23. The Children's Defense Fund.

total patient load. In 1978, 40% of the pediatricians who accepted Medicaid patients in New York State imposed such limitations; 49.5% did so in 1983. The primary reason given for this was the level of Medicaid reimbursement. In fact, despite improvements, New York State's Medicaid reimbursement rates continue to be among the nation's lowest, covering only 68.75% of fees for well-child visits in 1983, and only 56.0% for follow-up visits.[11]

New York State's Child/Teen Health Program has not met the preventive health care needs of children enrolled in Medicaid. Within the Medicaid program, the Early and Periodic Screening, Detection and Treatment Program (EPSDT), known in New York State as the Child/Teen Health Program (C/THP), was designed to provide preventive health care services to Medicaid-enrolled children. Added to the Medicaid system in 1967, the EPSDT program carries a case-finding mandate that requires states to undertake outreach and case-management activities to ensure that all enrolled children are provided with appropriate screening and treatment services, as well as to provide assistance in the scheduling of and traveling to appointments.[12]

According to the American Academy of Pediatrics (AAP), which monitors the provision of EPSDT services to children, New York State's plan is generous in comparison to other states in its inclusion of children in

---

11. "Trends in Pediatrician Participation in State Medicaid Programs," State Report for New York, January 1985, American Academy of Pediatrics, pp. 10-11, 14.

12. S. Rosenbaum and K. Johnson, "Providing Health Care for Low-income Children: Reconciling Child Health Goals with Child Health Financing Realities," The Milbank Quarterly, Vol 64, No. 3, 1986, p. 454 ff.

two-parent working families if their income level is sufficiently low,[13] and in its extension of benefits through age 21 (other states terminate benefits at the age of 18).[14] However, the AAP notes that New York State's reimbursement rates for EPSDT services are quite low, and that statewide participation rates are woefully inadequate. In 1986, despite recent revisions in both regulations and procedures designed to make the EPSDT system easier to use, official records show that only 14% of the children who were enrolled to receive EPSDT screening services did so.

Percent of Enrolled Children Receiving EPSDT Exams in 1986

	Eligible	Received exams	Percent
NEW YORK STATE	981,079	137,716	14.0%
Birth - 5	365,477	116,033	31.7%
6 - 20	615,602	21,683	3.5%
NEW YORK CITY	650,186	58,510	9.0%
Birth - 5	236,418	53,283	22.5%
6 - 20	413,768	5,227	1.3%
UPSTATE	330,893	79,206	23.9%
Birth - 5	129,059	62,750	48.6%
6 - 20	201,834	16,456	8.2%

Source: Child/Teen Health Program (C/THP) Monthly Management Report Summary for 1986.

13. Under federal EPSDT guidelines, some children who do not otherwise qualify for Medicaid may receive preventive services if the state plan includes them as "medically needy" populations. This is possible when a child's projected medical expenses would reduce the family to poverty income in a six-month period.

14. American Academy of Pediatrics, Medicaid State Report, 1986, p. 3.

Of those children from birth to age five, 31.7% were served by the Child/Teen Health Program, while only 3.5% of school-age children received services. Although there is reason to believe that some additional children may have received physical examinations that were not recorded by Medicaid, these valuable preventive health care services clearly are not reaching thousands of New York State's Medicaid-enrolled children.

The low utilization rates, especially when combined with New York State's extremely restrictive Medicaid eligibility requirements and the inadequate number of pediatricians who will accept all Medicaid patients, mean that far too few of New York State's poor children are receiving the preventive health care services to which they are entitled by law. In fact, only 0.1% of all New York State funds spent on Medicaid went to purchase EPSDT screening services.[15]

Several possible explanations can be offered for the low utilization rates. First, the scarcity of physicians accepting Medicaid or EPSDT patients severely limits access to these services. This is particularly troublesome in rural areas, where a general scarcity of health care providers makes it less likely that accessible and/or affordable alternatives will be found by poor families. Second, although New York State has targeted special outreach efforts to the birth-to-age-5 category (thus the higher participation rate for this age group), activities to reach the school-age population are limited to oral information-giving by Social Service workers at the time a family becomes enrolled for Medicaid,

---

15. American Academy of Pediatrics, EPSDT State Report (draft), 1987, p. 3.

and letters informing parents of eligibility.[16] This approach is too passive, particularly for parents who lack knowledge about the importance of regular preventive health care visits, or who, lacking health insurance or economic resources, have learned to defer any non-urgent medical expenses. Third, many families suffer interruptions in eligibility, and may not qualify for services in accordance with the schedule of allowable visits. Whatever the reasons, Governor Cuomo noted the low utilization rates and called for a revision of the program's regulations in his 1987 State of the State message to require that all hospitals, outpatient departments and freestanding clinics providing pediatric care perform C/THP examinations.[17]

An increasing number of children from non-Medicaid eligible families lack health insurance benefits or are inadequately insured. Between 1980 and 1984, the number of uninsured New Yorkers rose by 454,000 or 23%; the total number of uninsured New Yorkers rose to more than 2.4 million.[18] Because most health insurance is employer-sponsored, the unemployed are more likely than others to be uninsured. But in New York State, more than half of those newly uninsured--248,000--were employed, and approximately 80% of New Yorkers without health insurance are part of families in which someone is working.[19]

---

16. New York City Medical Assistance Program, under a special C/THP outreach initiative, sent letters last year to every Medicaid-enrolled 16-21 year old. Data is not yet available as to whether this has increased participation rates, either in C/THP or regular Medicaid services.

17. M. M. Cuomo, "State of the State Message", 1987, p. 74.

18. "New Yorkers are Losing Their Health Insurance," p. 3.

19. Ibid., p. 7.

This increase in medical indigency--and the accompanying increase in "working poverty"--reflects disturbing national and state-level trends in the structure of the labor market. Despite the fact that approximately 320,000 more people were employed in New York in 1984 than had been so in 1980, the number of **employed** persons living below the federal poverty standard in New York State increased during that interval by 157,000.[20] The new jobs created by the growing service sector are overwhelmingly low-paid and often part-time. Even when full-time, these jobs often offer fewer benefits than the manufacturing jobs they are replacing. In 1980, almost one employer in five did not contribute to workers' premiums for dependent coverage. Subsequently, in a national survey of employer health insurance practices, one-third of the employers responded that they had cut back their contributions to employees' (and the employees' dependents) health insurance premiums.[21] As a result, in 1985, 29% of all uninsured children lived in families headed by a worker with employer-based health coverage.[22]

In New York State, 28.9% of persons who were poor (with family income below the federal poverty standard), 23.6 % of the near-poor (with income from at poverty level to 1.49 times it) and 18% of low-income persons (with income 1.5 to 1.99 times the poverty level) lacked health coverage of any kind.[23]

---

20. "New York's Poor: A Growing Problem," p. 4.

21. S. Rosenbaum, Testimony before the Select Committee on Children, Youth and Families, March 23, 1987, p. 6.

22. "11 Million Children Have No Health Insurance, EBRI News, Employee Benefit Research Institute, March, 1987, p. 1.

23. "New Yorkers are Losing Their Health Insurance," p. 8.

In addition to the uninsured, there are also many underinsured, whose health insurance covers only major procedures, or requires deductibles and/or copayment, and limits the extent of reimbursement. In 1976, for example, a national study found that although 86% and 87% respectively of school-age children were insured for hospital and surgical expenses, only 51% were insured for outpatient visits and 33% for outpatient drug costs.[24] Yet these are precisely the areas of coverage that most affect utilization of preventive health care resources. While partial insurance is preferable to no coverage at all, research confirms that higher patient-contribution requirements tend to decrease the use of medical services, with the greatest impact on preventive care.

Those children not covered by insurance are significantly less likely to receive medical care than those with either Medicaid or private insurance. A 1977 national study of uninsured and inadequately insured children found that while 73.7% of all privately insured children and 67.1% of Medicaid-covered children had seen a doctor in the past year, only 56.7% of uninsured children had seen a doctor in the previous year.[25]

This finding is reinforced by research on the impact of Arizona's lack of a Medicaid program before 1982, which found that poor children saw

---

24. D. D. Dutton, "Children's Health Care," pp. 391-394.

25. J. D. Kasper, "Children at risk: The uninsured and the inadequately insured," paper presented at the Annual Meetings of the American Public Health Association, Maternal and Child Health Section, September 1986, unpaged, Table 9.

physicians 40% less often, on average, than comparable poor children in states with Medicaid programs.[26]

When uninsured or inadequately insured children do receive care, they are far more likely to use institutional providers, who are more costly than private physicians, and more often public hospitals than private ones. They also are more likely to use hospital emergency rooms for non-urgent care than children in families with either Medicaid or private health coverage.[27]

Taken together, the inadequacy of the Medicaid system and the growing problem of medical indigency place a financial burden on New York State's low-income families--those already most at risk of suffering poor health. In the face of the ever increasing cost of medical care and the declining economic status of New York State's families, the end result is all too clear: thousands of children are not getting the medical services they need to grow up healthy.

Age-Related Constraints

An increasing number of health professionals have come to view adolescents as a particularly hard-to-reach group within the general population, regardless of socioeconomic status. Paradoxically, while they are the only group for whom the mortality rate has increased in

---

26. R. J. Blendon, L. H. Aiken, H. B. Breemean, B. L. Kirkman-Liff and J. W. Murphy, "Uncompensated Care by Hospitals Or Public Insurance For The Poor: Does It Make A Difference?" The New England Journal of Medicine, May 1, 1986, pp. 1160-1163.

27. B. Weitzman, "Getting Care: Poor Children and New York City Hospitals," United Hospital Fund of New York, April 1987, p. 17.

the last twenty years, adolescents have the lowest frequency of doctors' visits of any group in the population.[28]

In addition to suffering from a higher frequency of acute or short-term health problems than any group other than younger children, adolescents' health problems are different from those of any other age group.[29] In 1982, the World Health Organization classified these problems in four categories: 1) those health problems related to growth and development; 2) violence and risk-taking behavior that now is the leading cause of death among teenagers; 3) sex-related problems, including pregnancy, and sexually transmitted diseases; and 4) the psychological and emotional problems that seem to affect many teenagers in this period of transition from childhood to adulthood.[30]

The latter three sets of problems have given rise to the term "new morbidity" to collectively describe diseases and causes of ill health and occasionally death that have social rather than biological origins. Although other age groups are not immune to these problems, their incidence is highest among teenagers.[31] Included in the list of new teenage morbidity problems are alcohol and substance abuse, violence and risk-taking behavior, suicide, mental health problems and teenage pregnancy. To make

---

28. American Medical Association, "White Paper on Adolescent Health," 1986.

29. Children's Defense Fund, "Building Health Programs for Teenagers," 1986, p.4

30. "Reaching Adolescents: An interview with Dr. Robert L. Johnson," in Family Life Matters, Number 1, Summer 1987, pp. 1 & 4.

31. "Building Health Programs for Teenagers," pp. 5-7.

matters worse, many pediatricians and general practitioners feel ill-equipped to deal with these problems.

> One inner-city clinic serving children and youths reported that in 1983, out of a population of 18,000 patients younger than 18, 51% of all hospitalizations were related to sexual activity (abortions, deliveries, and sexually transmitted diseases). Trauma (accidents and injuries) accounted for another 24% of admissions. Only one in four hospitalizations was for the "typical" range of pediatric problems.[32]

Violence has declined as a cause of death (although rates remain high), but suicide is increasingly frequent. Moreover, while approximately 6,500 suicides are expected to be reported in 1987, experts believe that the "real" number of teenagers who kill themselves may be four times that high, and that ten times as many attempt suicide. These attempts and deaths are unreported, or the causes of death and injury are masked in such categories as "one-car accidents."[33]

Teenage pregnancy, though infrequently a cause of death, also threatens the well-being of adolescents. Teen mothers are more likely than other teens to drop out of school and to live in poverty. And many teen fathers drop out to find work to support their children.[34]

Clearly, teenagers are a medically needy population. Yet they are the most medically underserved group in the population, as measured by several

---

32. "Building Health Programs for Teenagers," p. 6.

33. R. Dempsey, "The Trauma of Adolescent Suicide," National Association of Secondary School Principals, 1987, reported in Education Week, Health column, January 28, 1987, p. 4.

34. Children's Defense Fund, "Adolescent Pregnancy: An Anatomy of a Social Problem in Search of Comprehensive Solutions", January 1987, p. 5.

different indicators of health care utilization. Three kinds of barriers inhibit their access to the medical care.

Cost: Like younger children, many teenagers are without health insurance. In 1980, 7% of all teenagers were uninsured and 14% had coverage for only part of the year. In addition, those adolescents who depend on Medicaid are the least likely of all Medicaid children to be covered for the full year.[35]

At the same time, providing appropriate medical services for adolescents is more time-consuming than for younger children (and therefore costly, at least to the doctor) because of the many health issues that require discussion and "anticipatory guidance," and the need to allow the teenager to open up and reveal the real nature of his or her concerns.

Even for affluent adolescents, cost may be a factor if they wish to seek care independently of their parents. Private physicians' fees, even assuming some insurance reimbursement, are too high for teenagers to afford. And many "low-cost" clinics may be both absolutely and psychologically beyond the financial capabilities of most adolescents.

Accessibility: Young children are taken to the doctor by parents, and most adults usually can get to the doctor's office on their own. Adolescents, however, often have difficulty reaching the health services they need, particularly in areas that lack adequate public transportation.

---

35. Children's Defense Fund, "Building Health Programs for Teenagers," May 1986, p. 9.

Too often health services hold office hours when students are in school; the best community-based adolescent health programs offer services during evening or weekend hours, but staff costs are often higher for these hours, and sometimes it is difficult to find any health professionals who are willing to work at these hours, especially in poor urban neighborhoods.

Finally, legal consent issues also interfere with an adolescent's ability to gain access to health services. New York State explicitly permits adolescents to consent for treatment only in cases of emergency, or when treatment is related to pregnancy, venereal disease, or alcohol or drug abuse. While these issues account for a substantial proportion of adolescent health needs, the majority of teenagers' health concerns do not fall into these categories. As a result, adolescents may be forced to do without badly needed services if they wish to seek them independently or if their parents are unable or unwilling to help them.

Appropriateness: Perhaps the most difficult issue to address in adolescent health care is the inadequate preparation in adolescent medicine that most medical school programs provide their students. In 1985, more than 30% of the major pediatric residency programs did not include a section on adolescent medicine; even where programs existed, residents in more than half of these programs spent less than 15% of their time working directly with adolescents.[36] The weakness of the preparation is reflected in the finding that fewer than 60% of two groups of residents surveyed considered themselves prepared to provide "contraceptive counseling,

---

36. G. Commerci, Report of the Ad-Hoc Committee on Pediatric Residency Training. Read before the Society for Adolescent Medicine Annual Meeting, 1985, in C. Irwin, "Why Adolescent Medicine?" Journal of Adolescent Health Care, Vol. 7, No. 6 Supplement, November 1986, p.5S.

adolescent history-taking, counseling, evaluation of psychopathology, and treatment of dysmenorrhea and hypertension."[37]

In addition to the specific skills mentioned above, some pediatricians have difficulty understanding the intellectual development of adolescents and the impact of their changing cognitive and affective characteristics on a doctor-patient relationship that often is no longer mediated by a parent. Finally, the confidentiality of services provided to an adolescent patient by a family pediatrician may be inherently threatened by the doctor's historic relationship to the parents. Such confidentiality, however, is essential if young people are to feel comfortable enough to tell the doctor what is troubling them or to ask the questions to which they may desperately need answers.

The limitations on the appropriateness of medical care available to adolescents of any socioeconomic status are sharply revealed in a study of middle-class suburban adolescents with ready access to medical care. Although 90% of the group surveyed had a regular private phsyician and 85% had visited the physician within the past year, less than half were willing to seek aid from the same physician concerning matters of sexuality, substance abuse or emotional problems.[38]

---

37. M. I. Cohen, "Importance, Implementation, and Impact of the Adolescent Medicine Components of the Report of the Task Force on Pediatric Education," Journal of Adolescent Health Care, 1980, cited in C. Irwin, p. 5S.

38. A. Marks, J. Malizio, J. Hoch, R. Brody and M. Fisher, "Assessment of Health Needs and Willingness to Utilize Health Care Resources of Adolescents in a Suburban Population," Journal of Pediatrics, March 1983, p. 459.

Geographic Constraints

Despite pastoral images of rural life as quiet, pure, and wholesome, the rural areas of New York State, and the rest of the country, are experiencing increasing economic difficulties. The percentage of families in poverty in the most rural counties of the state is almost the same as in the most urban--16.0% and 16.3% respectively.[39]

The children in the most rural counties also are poor; in 19 of the 57 counties outside New York City, more than 15% of the children live in families with incomes below the povery level.[40] In 13 counties more than 10% of the children live in families qualifying for Aid to Families with Dependent Children (AFDC) benefits.[41]

These statistics mean that many rural children are not receiving the health care they need, especially preventive care services. For rural schoolchildren, however, geographic isolation and low population density also mean a relative scarcity of health providers, particularly those serving low-income children.

Although more rural New Yorkers are eligible for Medicaid assistance than in urban areas, as a whole they use relatively fewer Medicaid services than do their urban counterparts. According to the Legislative Commission on Rural Resources, the explanation may be found in "limited

---

39. New York State Legislative Commission on Rural Resources, Overall Tasks and Background Information, prepared for participants in the Rural Health Symposium, April 29-May 1, 1987, p.51.

40. "Child and Adolescent Health Profile." Selected New York State data compiled by Welfare Research, Inc. for the conference "Youth 2000: Imperatives for Action," April 27-28, 1987, p. 5.

41. "Child and Adolescent Health Profile," p. 7.

access to information about health options and services in rural areas, along with fewer health support services."[42] (The Child/Teen Health Plan, with a special outreach effort for 0-5 year olds, is an exception to this pattern).

Indeed, regardless of income, rural New Yorkers seeking health care also have a harder time finding individual private providers than their urban counterparts, due to "chronic shortages and geographic maldistribution of skilled health care personnel" in rural areas.[43] As a result, other health care institutions must play the role of primary care provider. Community health centers are one important source of care in rural areas, especially for children and uninsured families. But in New York State, although patient encounters increased by 12.9%, federal funding decreased by 7.2% between 1983 and 1985.[44]

Hospital outpatient departments also provide care to low-income patients, but in 1983, only 20 of 93 (21.5%) rural hospitals in New York State had outpatient departments, as compared to 114 of 188 (60.6%) hospitals in urban counties.[45]

Similarly, diagnostic and treatment centers, although increasing in number, still serve far too few rural residents of New York State. This is

---

42. "Overall Tasks and Background Information," New York State Legislative Commission on Rural Resources," pp. 66-67.

43. D. F. Perry, "A Paper on Issues in Rural Health Care Delivery," prepared for the Legislative Workshop: "Toward a Rural Health Care Policy", November 1985, p. 7.

44. U.S. Department of Health and Human Services, Region II, Office of Grants Management, Personal communication.

45. "Overall Tasks and Background Information," p. 76.

particularly troublesome, both because the patients they might serve usually have no other source of medical care and because these centers have been found to provide these valuable services at a lower cost than other primary care providers.[46]

Taken together, the problems affecting rural health care delivery systems are complex and daunting:

> a growing proportion of high-risk populations; large geographic distances between providers and clients; lack of personal mobility; isolation; low population density; a high proportion of economically hard-pressed populations; relatively less developed and more fragmented community support services; uneven distributrion of health services and personnel; insufficient or inappropriate housing, education and training opportunities [for health care professionals]; and relatively high cost for services."[47]

While the specifics vary from one rural locality to another, "almost all are worse off than their metropolitan cousins."[48]

Constraints Imposed by Changing Family and Work Patterns

Traditionally, children's health care has been the responsibility of full-time or part-time homemakers, rather than of parents who work full-time outside the home. Consequently, working parents' responsibilities have gained little recognition or support from employers. Employers' policies regarding dependent care leave, especially when the child in question is not sick, therefore can prove a significant barrier to the assumption of health care responsibilities by working parents.

---

46. "Overall Tasks and Background Information," p. 76.

47. E. Hall and W. Marcus, "A Paper on Developing a Workable State-Local Public-Private Partnership System of Rural Health Services." Prepared for workshop: "Toward a Rural Health Care Policy," November, 1985, p. 5.

48. Ibid.

In most cases, the parent responsible for children's health care has been the mother. But as more women enter the workforce, fewer mothers are available throughout their children's childhood to take them to the doctor, especially for preventive health care. In 1973, 42% of school-age children had mothers employed outside the home; by 1983 that proportion had increased to 59%.[49] Moreover, seeking medical care usually requires leaving the workplace and traveling to the doctor, often for greater distances than in past years, when home, school, and community medical resources were all close at hand, or when physicians made house calls. As a result, fewer parents are likely to take their children to pediatricians for the recommended preventive health services.

The phenomenon of both parents' working outside the home cuts across socioeconomic groups, but the associated problems hit especially hard on parents in low paid jobs, where a doctor's visit can mean losing a day's wages. This pattern of reduced parental availability has given rise to an increase in the number of children who are sent to school even when mildly ill, and to the development of centers that will care for mildly sick children while their parents are at work.[50]

Summary

Many of New York State's school-age children now face substantial obstacles to obtaining primary and preventive health care services. Economic barriers are the single most powerful factor constraining access

---

49. Special Report on the National School Health Services Program, Robert Wood Johnson Foundation, Number One, 1985, p. 7.

50. Education Week, "Health" column, April 15, 1987, p. 4.

to primary and preventive health care for children, affecting not only whether or not a child receives care, but also how timely, appropriate, and well-qualified the care will be. The impact of economic constraints, however, may be mitigated by the ready availability of free or low-cost services. School-based health clinics, located in schools that have substantial proportions of medically underserved students, provide health care services in a location that is easily accessible to school-age children. This not only makes it easy for students to seek care at the clinics, but also for health care professionals to reach out to students whose families, for economic reasons, have not been able to use preventive health care resources systematically, contributing to more frequent health problems.

Adolescence, for both poor and affluent youth, is associated with barriers to appropriate and timely use of health care. Although they continue to suffer from some of the conditions that affect small children, many adolescents have health concerns that differ significantly from those of younger children or adults. Problems like depression, suicide, risk-taking behavior, alcohol and drug abuse, sexually transmitted diseases, and adolescent pregnancy--termed the "new morbidity"--all take a toll on the health of young people, regardless of economic status. These problems are compounded by the scarcity of health professionals with both the training and experience to address these issues, and the high cost of health services relative to the economic resources of (in general) financially dependent adolescents. School-based clinics, like free-standing adolescent health clinics, have staff who are specially prepared to deal with the complex problems of young people in the midst of major emotional, physical, and intellectual transitions. Moreover, locating a clinic within (or

adjacent to) a school offers an additional advantage in accommodating adolescent development: it makes the clinic easily accessible for adolescents to get the services they need--they are apt not to follow through on self-care if it is at all inconvenient.

Rural isolation poses significant problems for the delivery of health care services. Medical facilities often are not easily accessible, and a combination of economic and geographic factors results in a scarcity of health care providers, especially for low-income patients. Since most children between the ages of five and eighteen spend most of their days in one place, school-based health clinics are an ideal location for delivering preventive and primary health care services in rural areas.

Finally, as economic pressures and changes in family structure have forced both parents in more families into the labor market, traditional ways of securing preventive health care services are increasingly inadequate. Mothers, most often the individuals responsible for taking children to the doctor, now often work outside the home, and disproportionately in jobs where taking time off for visits to doctors means a loss of pay. School-based clinics, by delivering health care services to the child in the school setting, respond to the health care needs of children in families where both parents work outside the home.

The next chapter describes current efforts in New York State to demonstrate the viability of these clinics in selected medically underserved areas.

Chapter 3

School-Based Health Clinics in New York State

Some Historical Background

Although the Progressive reformers advocated extensive school health services--including clinics--at the beginning of this Century, the first school-based health clinics in the United States[1] were established in 1967 in Cambridge, Massachusetts, by Harvard Medical School professor Philip Porter. After successfully convincing the Cambridge city government to combine the five separate agencies that provided child health services, Porter placed health clinics in elementary schools where children in need of services were located, and staffed the clinics with nurse practitioners as the former school nurses retired. Since the program's inception,

> immunization levels have reached 98 percent (compared to a national average about 60 percent). Incidence of children with elevated blood lead levels has dropped from 7 percent to .5 percent. And the number of children with anemia has been reduced from 16 percent to 4 percent. Further, inappropriate utilization of the Cambridge Hospital emergency ward has been almost halved.[2]

In 1975, impressed with the success of the Cambridge program, the Robert Wood Johnson Foundation made grants to three school systems to initiate three different models of school health clinics, each using nurse practitioners working under the supervision of physicians. In 1977, the Foundation announced its intention to demonstrate school health clinics on a national basis. After reviewing proposals from 39 states, three states received grants in 1978 to initiate school health programs. New York State was among the recipients, and programs in Chenango County and

---

1. School-based clinics already had been demonstrated in England, with considerable success in improving children's health and school attendance at a low cost.

2. Robert Wood Johnson Foundation, "Special Report," 1979, No. 1,pp. 15 &16.

Newburgh were begun, with a commitment of five years of demonstration funding. Although some of the projects served adolescents, most focused on the elementary school level.

The first high school-level clinic was opened in Dallas in 1970 as a continuation of two elementary school clinics initiated locally in 1968. In St. Paul, Minnesota, in 1973, the Maternal and Infant Care Program of the St. Paul Ramsey Hospital, concerned about an increasing teenage pregnancy rate and high rates of infant mortality and low birthweight among the babies born to these teenagers, opened a clinic in one high school, offering prenatal and postpartum services, testing and treatment of sexually transmitted diseases, Pap smears, pregnancy testing, and contraceptive information and counseling. Clinic administrators quickly responded to low utilization of the clinic by adding a range of other services needed by adolescents--athletic, job, and college physicals; immunizations; and a weight-control program. These additional services immediately yielded greatly increased rates of student use of the clinic. The clinics (now replicated in four St. Paul high schools following the closing of the initial host school in 1976) contributed to the reduction of teenage birth rates from 79 per thousand in 1973 to 27 per thousand in 1976, lowering as well the repeat birth rate among students who chose to carry their pregnancies to term.[3]

After a slow beginning, school-based clinics have grown steadily across the country. Almost one hundred high school-level clinics are now

---

3. D. Kirby, with S. Lovick, J. Levin-Epstein, E. Hadley, "School-Based Health Clinics: An Emerging Approach of Improving Adolescent Health and Addressing Teenage Pregnancy," Center For Population Options, April 1985, p.14.

operating (with more in the planning stages), while hundreds more elementary and junior high school sites are providing care to students in school districts where substantial proportions of children are medically underserved.

New York State School Health Laws

The principal statute governing school health practices in New York State is Article 19 of the New York State Education Law, which requires all local school districts to provide "medical inspection . . . to all pupils attending the public schools in this state, except in the city school districts of New York, Buffalo, and Rochester." (These three cities are exempt because school health services are provided by their municipal health departments, as was already the practice when the school health laws were passed.) No state funds are provided for these services; while the State Education Department has regulatory authority over school health services, funds to support local school health services services come from the local tax-levy resources, whether the services are provided through the school system or the local health department.

In addition to requiring that each local school district hire a "medical inspector" (a licensed physician), the school health law requires medical inspection of each child upon entry into school to determine the existence of disease or physical defect, and evidence of periodic physical examinations (before first, third, seventh, and tenth grade), or performance of an examination by the medical inspector, including appropriate immunizations. In addition, the law mandates eye, ear, and scoliosis testing with varying frequency, and sickle cell anemia tests once

between the ages of four and nine in all city school districts. It also mandates that school districts keep health records for all students.[4]

In a State Education Department document that seems to reflect the Robert Wood Johnson projects and to presage the School Health Demonstration Project (described in the following section), the **potential** scope and range of school health services are further elaborated as including:

- o physical assessment and screening to determine the health status of all children, grades K - 12;
- o casefinding of all children with significant health or educational problems;
- o development of a specific care plan if problems are found;
- o case-management, including referral and follow-up;
- o modification of a child's educational environment, if needed;
- o provision of health instruction and health counseling regarding individual health problems or concerns; and
- o anticipatory guidance and preventive services related to nutrition, oral hygiene, alcohol and other drug use, safety, sexual activity and teenage pregnancy.[5]

Except in the case of districts participating in the School Health Demonstration Project, however, no additional state funds are provided to support these kinds of services, and there is no mandate to provide services beyond the basic ones spelled out in the School Health Services Law. In reality, the scope of most school health services in New York State is quite circumscribed, limited to simple screening tests for height,

---

4. New York State Education Law, Article 19, and Section 136 of the Commissioner of Education's Regulations.

5. School Health Digest, January-February, 1981, description prepared by the Division of Physical Education, Fitness, Health, Nutrition, and Safety Services.

weight, vision, hearing, and scoliosis, and the treatment of minor injuries (first aid). One-quarter of the schools (excluding those in the three exempt cities) have neither school nurses nor school-nurse teachers.[6]

New York State's School Health Demonstration Program

New York State's school-based health clinics grew in part out of the process of grant submission for the 1978 Robert Wood Johnson Foundation's National School Health Services Program. The Geneva B. Scruggs Health Center in Buffalo had applied to receive funds for school clinics. When not selected, the Center turned to Buffalo Assemblyman Arthur Eve, and state funds were allocated to support the development of a clinic that served five Buffalo school sites. Chapter 198 of the Laws of 1978 was passed to authorize the work of school nurse-practitioners both in Buffalo and in the two Robert Wood Johnson Foundation projects; it also provided that school districts could "provide improved and expanded school health services for preschool and school-age children," with preference in funding going to "districts in which a substantial number of children lack adequate access to health services." The law also added these school sites to the list of Medicaid-reimbursable facilities under Article 28 of the New York State Public Health Law, opening the door to federal funds for Medicaid-eligible children.

Three years later, at the request of the Black and Puerto Rican Caucus (which Arthur Eve chaired at that time), an interagency group with representatives from the Department of Health (DOH) and the New York State Council on Children and Families, in consultation with the Departments of

---

6. New York State Education Department, Bureau of Educational Data Services.

Education and Social Services, developed a proposal entitled "Plan for Pediatric Services in the Schools," which "specified criteria for identifying high-risk communities and selecting demonstration sites, recommended the scope of services to be provided, and outlined a plan for NYS DOH authority and funding."[7]

Chapter 50 was enacted in 1981, essentially supporting the replication of the existing school-based health clinics in additional medically underserved areas of New York State. It provided $1.8 million to initiate the six-year statewide School Health Demonstration Project in New York City, Rochester, and Buffalo.

Initially, nine grants were made to projects in these three cities. The grantees, selected on a competitive basis, were hospital ambulatory care centers and neighborhood health centers that outstationed health teams in local public and parochial elementary and junior high schools, and, in a few cases, Head Start or day care centers. The New York State Department of Health's model sponsored clinics linking schools and communities with health care facilities licensed under Article 28 of the Public Health Law, permitting the clinics to be reimbursed for services provided to students enrolled in Medicaid. The core staff model chosen consisted of a physician preceptor, a mid-level practitioner (nurse practitioner or physician's assistant) and a health aide and/or community worker. Clinic sites were chosen by a proposal process, with indicators of unmet health needs constituting a substantial factor in site selection.

---

7. "Health Services for High School Students: Assessment of the New York City (High) School-based Clinics Funded by the New York State Department of Health," Welfare Research, Inc., pp. 113-118.

In 1982-83, the first full year of operation, 55 sites provided health services to children. In each site, the host schools contributed clinic space, locked files, and telephones; in some cases additional services also were provided through in-kind contributions. Some schools also were able to attract private foundation support to broaden the scope of services offered beyond the level made possible by the basic state grant.

In 1983-84, the School Health Demonstration Project was expanded, this time with federal funds. With Maternal and Child Health (MCH) Block Grant Funds, six of the seven New York City grantees were able to open 44 additional sites, bringing the total to 99. In addition, the New York City Board of Education, impressed with the success of the projects at the elementary and junior high school levels, had requested that the Department of Health extend the program to the high school level. Using the MCH funds again, nine new clinics were opened in New York City high schools in 1985, following the same basic model as in other sites, with some modifications to address adolescent health care needs.

Because the funds for school-based health clinics were provided by demonstration legislation, evaluation of the program accompanied its implementation. Welfare Research, Inc., in evaluating the School Health Demonstration Project in the elementary and junior high schools, found that the clinics had dramatically improved access to primary and preventive medical care for students who were medically underserved. Specifically, the clinics had diagnosed a significant number of previously unknown medical problems among the students who visited the clinics, among them child abuse or maltreatment and uncorrected vision problems that could interfere with the students' ability to function in school. In addition,

students received earlier treatment for problems, better follow-up than with previous providers, and made fewer emergency room visits than they would have without the clinic.[8]

New York City's Clinic Controversy

Controversy erupted in October 1986, when it was learned that contraceptives were being distributed in some of the nine high school clinics created in 1985 (as would have been the practice in any non-school-based comprehensive clinics that treated adolescents). Charges also were made that the placement of the clinics was racially motivated--a veiled attempt to control the population growth of ethnic minority groups.

The New York City Board of Education called a six-month moratorium on dispensing contraceptives (clinics were permitted to write prescriptions for contraceptives), and contracted with Welfare Research, Inc. (WRI) to evaluate the high school clinics, paying particular attention to the issues stimulating the controversy. The evaluation, made public in June 1987, found that there was overwhelming support for the clinics among both parents and students. Contrary to public expectations, most parents strongly supported the availability of reproductive health care services. Of the parents interviewed in the WRI study, 92 percent wished their

---

8. "Evaluation of the New York State School Health Demonstration Program: Final Report," Welfare Research, Inc., September 1986, pp. 14-17. One provider requested its clinic personnel to keep track of students' cases where the lack of clinic treatment had averted an emergency room visit. Based on the results, the provider estimated that each clinic site could "conservatively prevent $70,000 of unnecessary expenditures on an annual basis." This figure covers only **appropriate** emergency room visits; **inappropriate** use of the emergency room (as was the case in 6 percent of the families included in the WRI research) was not studied.

children to receive abstinence counseling. Almost as many parents, however, rejected such counseling as the sole approach; 85 percent wanted their children to receive family planning counseling, 61 percent wanted their children to receive contraceptives from the clinic, either directly or by prescriptions to be filled elsewhere, and 55% preferred on-site distribution. Almost all the parents (98%) wanted a clinic in their child's school.[9]

Finally, in addressing the question of alleged racial motivation in the choice of the 9 high school sites, WRI examined the process used by the New York State Department of Health to weigh the 14 proposals submitted for high school clinics.[10] WRI found that each of the schools in which clinics were opened was not only in a high-need area but also had well-qualified local health providers. The schools not chosen either were not located where unmet health needs were as high as in chosen schools, or did not have a local health provider adequately equipped to operate the clinic.[11]

In June 1987, shortly after the release of the evaluation report, the New York City Board of Education voted to continue the high school clinic program, with the eventual goal of situating a clinic in every high school.

---

9. "Health Services for High School Students, pp. 111, 112.

10. The Requests for Proposals to establish high school clinics were sent to 120 potential back-up providers; only 14 submitted applications to initiate projects.

11. Ibid., pp. 150-157.

The Board of Education also voted to continue the practice of providing prescriptions for contraceptives in the clinics.[12]

The school-based clinic model has now been both demonstrated and evaluated in New York State as a viable delivery mechanism for providing primary and preventive health care services to medically underserved school-age children. It has attracted the attention of local health officials and advocates, and an increasing number of localities in New York State have expressed interest in initiating school-based clinics in their areas. In Spring 1987, the New York State Legislature voted to increase funding for school-based health clinics by $1.2 million, bringing the total state funding level to $4.2 million.[13] In addition, the Robert Wood Johnson Foundation announced that it will support three new high school-level clinics in New York City as part of its School-Based Adolescent Health Care Program.

The next chapter discusses the rationale for broader implementation of school-based health clinics and presents key concerns in the implementation of a broad-based initiative to provide primary and preventive health care services to students in medically underserved areas.

---

12. At the time, a majority of the members of the Board of Education favored dispensing contraceptives in the schools; the resolution before the Board at that meeting did not, however, include on-site dispensing.

13. In addition to $3 million in legislative appropriations, the New York State Department of Health has committed $1.2 million in federal Maternal and Child Health Block Grants to the School Health Demonstration Programs.

Chapter 4

Implementing School-Based Health Clinics

School-based health clinics have been demonstrated in New York State at more than one hundred sites at the pre-school, elementary, junior high school, and high school levels, in both upstate and downstate urban centers and in several upstate rural counties. Repeated evaluations of the School Health Demonstration Program have found that these clinics are a viable mechanism for delivering badly needed health services to medically underserved children and that the clinics enjoy strong support from parents, teachers, and administrators.[1] School-based clinics also have garnered support nationally from such groups as the American Academy of Pediatrics and the Society for Adolescent Medicine, the National Education Association and the Committee for Economic Development.[2]

But there are 725 school districts and more than 3,900 schools in New York State, many in communities that, due to both economic and

---

1. " Health Services for High School Students: Assessment of the New York City (High) School-Based Clinics Funded by the New York State Department of Health," Welfare Research, Inc., June 1987, and "Evaluation of the New York State School Health Demonstration Program: Final Report," Welfare Research, Inc. September, 1986. See also by Welfare Research, Inc.: "Evaluation of the Impact of the New York State School Health Demonstration Project on School Attendance," (1984); "Evaluation of the New York State School Health Demonstration Program, September 1983 - June 1984," (1984); "Evaluation of the New York State School Health Demonstration Program, September 1982 - June 1983," (1983); "Findings of the School Health Demonstration Project Principals Survey (September 1983); "Findings of the School Health Demonstration Project Teacher Survey (July 1983). See also Robert Wood Johnson Foundation, "Special Report Number One," 1985.

2. "American Academcy of Pediatrics Guidelines: School-Based Health Clinics," approved March 4, 1987; Society for Adolescent Medicine, "Position Statement on School-Based Clinics," 1987 (forthcoming); National Education Association, "Resolution #C-9: Student Health and Personnel Services," July 1987; Committee for Economic Development, Children In Need: Investment Strategies for the Educationally Disadvantaged, pp. 51, 52.

geographic factors, lack adequate access to health care services. Free and reduced cost school-lunch eligibility rates provide an excellent indicator of the concentration of medically indigent students in New York State's schools and school districts, since the maximum family income of 185% of the federal poverty level also is considered by health policy experts to be the point below which most individuals are probably uninsured or Medicaid-eligible. In one third (206) of the 620 New York State districts that receive reimbursement for free and reduced cost lunches for low-income students, at least 30% of the student population qualifies for aid. At least 20% are eligible in an additional 22% (144) of the districts.[3]

The time is ripe for New York State to assume a position of national leadership by broadening its clinic initiative to serve more of the state's medically needy students, and by lengthening its commitment to the clinics to enable comprehensive long-range planning. Education reformers have long recognized the importance of good health in the education process, and modern school health laws are intended to assure that children are best equipped to take advantage of the education schools can offer them.

In New York State, thousands of school-age children are not as healthy as they should be because of their limited access to preventive and primary health care services. Many needlessly miss days of school when suffering from minor illnesses that are untreated, often seriously

---

3. New York State Department of Education, Bureau of Child Nutrition Services, 1986-87 eligibility rates. Some districts do not offer hot lunch programs and do not qualify for assistance; several districts that do serve hot lunches do not apply for assistance. The reimbursement programs in some large districts include children in parochial schools, while in other large districts, parochial school lunch reimbursements are handled separately by the local diocese.

disrupting their educational progress. Others may have difficulty functioning even when in school because their health is poor or they suffer from emotional problems that detract from learning. Health problems not only compromise the students' education but also constitute a burden for teachers and school administrators, who usually are not prepared, either by training or with resources, to deal with the medical and emotional problems of their students.[4] In their evaluation of the New York City high school clinics, for example, WRI found that, in one third of the students' cases reviewed as part of the evaluation, the student had brought at least one psychosocial problem to the attention of clinic staff.[5]

What is missing is a legislative mandate supporting school-based clinics as a valuable approach to addressing the unmet health care needs of thousands of students. This would enable thoughtful and comprehensive planning for the long-range implementation of the primary care model for expanded school health services in the districts that need them. As long as the School Health Demonstration Program remains in its current form, dependent on year-to-year extensions and funding, the development and operation of these clinics will remain narrow, preventing thousands of needy students from receiving adequate health care and from taking full advantage of their educational opportunities.

---

4. In the WRI evaluation reports of the School Health Demonstration Project cited above, both teachers and principals made clear that their support for the clinics was based both on the value of having medical services available to children clearly in need and on the fact that the clinics enabled teachers and administrators to concentrate on educating students.

5. "Health Services for High School Students," 1987, pp. 77-81.

We therefore recommend that the Governor and New York State Legislature authorize and allocate funds to support a planning process carried out under the auspices of the Council on Children and Families, bringing together government and state agency leaders, health care providers, legislators, advocates, and parent and student representatives to fashion a five-year plan for the broader implementation of school-based health clinics in medically underserved school districts in the state.

Key Implementation Issues

The experience of the New York State School Health Demonstration Project, as well as that of many other clinics around the country, provides policymakers and practitioners with useful guidelines about how best to set up new clinic projects. The following discussion of these implementation issues is organized around the key components of school-based health clinics described in Chapter 2.[6]

Target Population. We recommend that two kinds of measures be used to evaluate both the community's need for health care and the availability of health care resources in the community.

Although the school-based health clinic is a good model, it is not necessarily needed or appropriate for all students in all school districts--only for those who are medically underserved. These include students in high-risk districts, where a substantial number of children lack access to adequate health care, and all adolescents, given their special health needs and the lack of appropriate and accessible providers. Program implementation at the high school level, however, should begin, as on the elementary and junior high school level,

---

6. E. M. Hadley, S. R. Lovick, and D. Kirby, School-Based Health Clinics: A Guide to Implementing Programs, Center for Population Options, 1986, is an excellent step-by-step guide to implementing new programs at the high school level, based on the technical assistance provided by the Support Center for School-Based Clinics to dozens of adolescent clinics in different parts of the country.

districts where economic and geographic constraints limit access more severely than in less impoverished areas.[7]

The first measure used to target clinic projects should include standard health indicators used to determine a community's need for services, such as infant mortality rates; percent of babies born at low birthweights; percent of fully immunized children; hospitalization rates for pre-school and school-aged children; rates of adolescent pregnancy and birth; rates of sexually transmitted diseases; dental needs; suicide, homicide and accident rates, and rates of communicable illnessess. Since local health data collection and analysis may vary, some of these indicators are more easily retrievable than others; this list is intended to suggest the kinds of information that indicate the need for school-based health services.

The second evaluation measure should incorporate figures that reveal the accessibility and availability of health resources to the target population: the number of health care providers in the area, taking into account area of specialization and hours of practice to yield a full-time equivalent measure of available primary care and specialized care providers; the willingness of local providers to accept Medicaid patients or those without health insurance; the percent of the population that is Medicaid-eligible or medically indigent (indicated by the percent of the population with incomes at or below 185 percent of the poverty level), and the number of emergency room visits made for primary care. In addition, an

---

7. In June 1987 the New York City Board of Education announced its intention to support the establishment of school-based clinics in all city high schools. Minneapolis and Cleveland also are considering citywide implementation of school-based clinics serving adolescents.

assessment of local need should consider barriers to service, such as isolation and lack of transportation in rural areas, or language problems in urban centers, or age-related medical problems, like those encountered by adolescents.

Location: We recommend that the choice of clinic site, either within or adjacent to a school, be determined by the community's particular health care needs.

There has been considerable discussion over location--whether the clinic should be within or adjacent to a school. Although we lean more toward the within-school model, there are good arguments on both sides of this issue. Those in favor of locating the clinic within the school building stress that this is where the students are for the greatest part of their day. An internal site allows the clinic staff to interact informally with students as they pass through the building, increasing the likelihood that a student seeking care will feel comfortable enough to raise difficult and/or embarrassing concerns. It makes it easier for students to simply "drop by" to say hello or ask a question or to provide follow-up information, rather than their having to leave the building (which often requires a pass) for a more formal kind of interaction. Finally, many schools already have health facilities or other available space for a health suite.

Locating a clinic adjacent to a school has the advantage of accessibility to students who are not enrolled in the host school. This may be particularly useful if the host school has a small population and the clinic will also serve students from surrounding schools. It also permits the clinic to remain open when the school building is not, enabling

greater flexibility of hours and days of service. This may be particularly important where back-up providers are less accessible to students, as in rural areas.

Whether a district chooses an internal or an adjacent site, the clinic must be as accessible to students as possible. "Near-site" clinics, even a few blocks away, may seem a minor inconvenience for adults, but can make a critical difference in whether a child or adolescent feels comfortable and able to seek care in a timely manner.

> **Staffing: We recommend that the core team consist of a supervising pediatrician or family practitioner, a mid-level practitioner (with either of the first two also serving as clinic administrator), a health aide, and a psychologist or social worker, all working closely with health personnel already in the school, such as school nurses, school nurse-teachers, and/or health educators.**

The first three professionals listed in the recommendation now constitute the basic team in the School Health Demonstration Project. According to the Center for Population Options' School-Based Health Clinics: A Guide To Implementing Programs, the ideal staff for a clinic would include a physician (with training in the particular age group being served--e.g., adolescents if the clinic is in a high school); a clinic administrator; a full-time mid-level practitioner (also with age-specialized training); a full-time social worker; a psychologist; a nutritionist; a health/family life educator; a dental hygienist; a dentist; a medical assistant or nursing support staff, and a receptionist.[8] Clearly, not all clinics can assemble this kind of multidisciplinary staff, nor do most schools need full-time access to these services. Easy access

---

8. E.M. Hadley, S.R. Lovick, D. Kirby, op. cit., p. 62.

to this range of services, however, is a critical component of a successful clinic.

Discussions are now going on in New York State to add at least a part-time social worker to each project. (Most projects serve multiple sites). Based on the evaluation findings concerning the prevalence of psychosocial problems in the clinics already operating in New York State, we also recommend that a social worker or psychologist be available **on a full-time basis to each site**, especially at the adolescent level.

All school districts, under state law, must make personnel provisions to carry out mandated health screenings; most do so by hiring a school nurse. These nurses can have an important role to play in the clinic's operation, even though in most cases the school nurse is not an employee of the clinic but of the school itself or of the local health department. In addition to caring for students not enrolled in the clinic, school nurses can help obtain parental consent to enroll students in the clinic, can serve as liaison between students and the clinic, can complete a portion of the mandated screening examinations, and can assist in the health education process, taking charge of outreach presentations in the classroom. We recommend that the school nurses now in schools be retained and that existing school health services be integrated under the clinic "umbrella."

Range of Services: We recommend that clinics provide three kinds of services to students: preventive care, primary care, and health promotion and education.

Preventive health care services should include an annual comprehensive physical examination for each child; immunizations, if needed; hearing and vision screening, as well as screening for height, weight, scoliosis, lead

poisoning, dental problems, and sickle cell anemia. While school health laws currently mandate these screening examinations in all schools, the physical examinations required are neither annual nor as comprehensive as those offered in the School Health Demonstration Program clinics.

Primary care should include the diagnosis and treatment of children's health problems according to the medical protocols established by the provider health facility and approved by the New York State Department of Health, including both acute and chronic illness. When needed, prescriptions should be issued (or medication given) in response to medical problems, and, if required, students should be referred to the back-up provider for specialized care. Follow-up of all health problems identified, either during physical examinations or in providing primary care, is also an essential element in the range of services.

We recommend, as does the American Academy of Pediatrics in its statement on school-based health clinics, that clinic services follow the same guidelines promulgated for non-clinic-based pediatricians caring for school-age children.

In high school clinics, this includes reproductive health care.[9] Communities must decide how the clinic will approach sensitive issues, such as pregnancy, birth control and sexually transmitted diseases, according to local needs and values. However, we strongly recommend whatever mechanism is chosen to provide care--whether direct service or referral to nearby providers, that services to address the reproductive health care needs of the students not be avoided for fear of controversy.

---

9. American Academy of Pediatrics, Guidelines for Health Supervision of Children and Youth, 1981.

School-based clinics differ significantly from many private practitioners and free-standing health clinics in their emphasis on health promotion and education. Clinic staff, working with school personnel such as school nurses, teachers, and health educators, should provide students--and parents, whenever possible--with health information that enables them to better care for themselves and avoid major health problems. When needed, clinic staff should work with families where the child suffers from a chronic condition, such as asthma or sickle cell anemia, helping both the student and the family (and, in some cases, teachers) learn how to manage the problem. Finally, clinic personel should help students and parents learn how to make better use of the health care resources that are accessible to them, emphasizing the importance of preventive care.

Administrative Structure: We recommend that clinics not be run by the school, but by a professional health care or multiservice facility, except in rural areas lacking adequate alternatives.

Even if a school-based clinic is within an educational institution, school officials should not carry responsibility for the clinic. This separation of administration relieves school administrators of non-pedagogical responsibilities, avoids the often political nature of school staffing, and ensures that clinic personnel will be bound by the professional practice guidelines of medical facilities that employ them. In addition, as a separate administrative entity, the clinic can (and indeed, must) maintain students' records separate from all other school records, restricting access to information in these files to clinic personnel to insure complete confidentiality.

Provider relationship: We recommend that, in selecting a back-up provider districts place primary emphasis on the importance of the

provider's willingness and capacity to implement a holistic approach to dealing with the health care needs of students.

Because schools are open only part of the year and part of each day, arrangements must be made to provide back-up care when clinics are closed, or to provide specialized or follow-up care if a problem cannot be handled by the clinic. (Research both in New York State and elsewhere shows that such needs occur between 6 and 10 percent of the time).

The goals of school-based health clinics, like the needs of the students they serve, require a multidisciplinary approach, combining medical treatment with counseling, nutrition and health education, as well as a case management approach to resolve those issues that cause health-related problems for the students.

In addition, mid-level practitioners and other members of the clinic team need support and supervision as they conduct their work. We recommend that clinics be affiliated with a health facility such as a university medical or nursing school, a hospital or comunity health center, or a local health department; or with a physician group practice, where no other institution is appropriate.

<u>Community Relationship</u>: We recommend that clinics develop and maintain close ties with their host communities.

In order to effectively serve a community's children, the clinic must be responsive to the community's needs and values and must enjoy community support. Otherwise, it will be hampered as it tries to serve the children of the community. Strong community relationships facilitate the process of linking the clinic with local support services and building a partnership of individuals and organizations to address the community's health care

needs. In addition, some clinics initiated with private foundation grants have gained financial support from their communities, ranging from grants from local businesses, donations of services and equipment, to eventual tax-levy support for the work of the clinic.

Each clinic should form an Advisory Board to help monitor the clinic's progress and programs; review current programs; suggest new programs; examine and offer suggestions on written materials used by the clinic; play a public relations role with the community, and help the clinic raise additional funds.

Evaluation: We recommend that systematic evaluation continue during the expansion of the School Health Demonstration Program for a period of at least three years.

The evaluations of New York State's School Demonstration Program, conducted since its inception, proved helpful during this initial pilot phase in assessing the strengths and weaknesses of the school-based clinics, as well as the impact of the clinics on the students, staff, and parents in the schools being served. A systematic evaluation of the expansion of the school Health Demonstration Program to other medically underserved districts should address several important concerns. First, a comprehensive needs assessment should be conducted in all schools or districts selected to initiate clinics, both providing consistent information (across sites) for planning what kinds of services and staff will be needed in each new clinic, as well as identifying the scope and variety of health problems that each clinic will address. Second, a process evaluation should document the implementation of school-based clinics in different sites, noting important variations in establishing the clinic and in reaching medically underserved students. Finally, the

evaluation should assess the impact of the clinics, comparing students and schools being served with comparable populations in schools lacking clinics if at all possible.

Such an evaluation offers benefits beyond the obvious ability to assess the value of individual clinics. The development of data gathering tools for such an evaluation, constructed in cooperation with the local clinic providers, will provide inidividual clinic administrators with information to assist them in internal clinic management. In addition, the collection of data on health needs and health resources across the individual sites will provide the basis for state officials to plan more comprehensively how to meet the health needs of New York's children.

The next chapter discusses the best strategy for funding an extended school health clinic program.

Chapter 5

Funding School-Based Health Clinics in New York State

In 1,017 of the state's 3,902 schools, more than 30% of the students live in families receiving public assistance.[1] In more than 200 New York State school districts, more than 30% of the students live in families with incomes at or below 185% of the federal poverty level.[2] Although large numbers of poor and low-income students are clustered in urban areas like New York City, Rochester, Buffalo, Yonkers, and Syracuse, thousands of others are concentrated in rural districts, where, in addition to economic barriers, geographic factors also constrain access to adequate health care.

For students like these, school-based clinics have proven an excellent mechanism for increasing access to free or low-cost preventive and primary health care services in the School Health Demonstration Program clinics already in existence. The clinics also have played a vital role in helping students and their families develop more appropriate patterns of health care utilization, stressing more preventive and primary care, and less acute and emergency care. But the students attending more than nine hundred high-risk schools still lack access to adequate health care services.[3]

---

1. New York State Education Department, Bureau of Educational Data Services, 1986-87 school year data.

2. New York State Education Department, Child Nutrition Reimbursement Unit, 1986-87 school year data.

3. High-risk schools, for the purpose of this cost projection, are those where more than 30% of the student population live in families receiving public assistance.

Because clinics can be established in all different sizes of schools, in cooperation with several different kinds of health facilities as back-up providers, it is difficult to give a precise figure of how much it costs to provide preventive and primary care to a single student enrolled in a school-based clinic. Estimates range from $50 to $150 per student per year, regardless of the number of visits.[4] This compares favorably to the cost of providing care in private physician's offices, where the cost of an annual physical examination, standard laboratory tests, and a single acute care visit would cost from $100 to $175, with standard fees for each of these services varying accross the state. More often, however, poor and low-income children rely on institutional services, which are more expensive, either to the patient if he or she pays, or to the public, which reimburses the provider through Medicaid or support for the publicly funded facilities that serve the uninsured.

General Funding Strategy

A broader implementation of school-based clinics in medically underserved areas of New York State requires a solid foundation of state funding. **We recommend that funding for school-based clinics consist of four components: 1) a core state grant from the School Health Demonstration Program, 2) Medicaid funds for eligible students, 3) local matching funds, and 4) other federal, state and local resources, depending**

---

4. S. Pirani, Rx for Schoolchildren, Citizen's Committee for Children, 1983, p. 30. See also E. M. Hadley, S. R. Lovick, and D. Kirby, School-based Health Clinics: A Guide To Implementing Programs, Center for Population Options, 1986, p. 33. CPO's cost estimate is $150-$200, but this is based on serving only adolescents, whose special needs lead to higher costs.

on the population served by the clinic and the availability of other revenues.

The School Health Demonstration Program

The principal funding source for school-based health clinics in New York State is the **School Health Demonstration Program**, authorized by Chapter 198 of the Laws of 1978. Initially funded at $1.8 million in 1981, the legislature voted in 1987 to increase the funding to $3 million, with the understanding that new funds would both supplement the clinics that had operated without a cost-of-living increase since their inception, and to initiate several new projects.

Even this increase, however, is not adequate to meet the need (and the demand) for clinics in many other schools and school districts, and leaves substantial gaps in the current foundation for school-based clinics already in existence. Many clinics suffered turnover and had been forced to cut back services between 1981 and 1987 due to static funding levels. Most clinics, especially those serving high school and junior high school students, still lack adequate psychosocial support staff, despite a small allocation for each project from the new funds earmarked for this purpose.

Moreover, given the varying capacities of different kinds of health facilities to make substantial in-kind contributions to clinics (for example, assumption of laboratory and billing costs, residents' time, supplies, etc.), some projects are left with a greater proportion of uncovered costs than others. This is particularly troublesome when contemplating expanding the clinic program into areas where the existing health facilities may be both less able and less willing to commit

substantial resources to clinic projects than are those facilities already operating clinics.

We recommend that the Legislature increase the funding of the School Health Demonstration Program by $14 million over the next three years. In the first year of expansion (1988-89), $6 million above the current funding level will enable New York State to create approximately one hundred new clinics in the highest-risk districts, as well as to upgrade the existing clinics, permitting each high school and junior high school clinic site to hire a full-time social worker or psychologist, and each elementary school clinic to hire a part-time social worker or psychologist. With the addition of $4 million in new funds each year in 1989-90 and 1990-91, New York State will be able to establish clinics in approximately one-half the state's high-risk schools by 1991.

Medicaid

Federal Medicaid is unlikely to provide more than partial funding for school-based health clinics, particularly in non-urban, economically heterogeneous areas. Nonetheless, the Medicaid share of funding for clinics has been less productive than expected; a long-range funding strategy must include maximizing the federal reimbursements for services provided to Medicaid-eligible children.

Several different problems currently reduce the amount of Medicaid reimbursement the existing clinics receive:

Eligibility: New York State's restrictive Medicaid eligibility standard is the primary factor reducing Medicaid funds for the clinics. Despite efforts by health care advocates and the leadership of the New York

State Assembly, attempts to raise the eligibility threshold to the federal poverty level for all families have yet to succeed. By 1985, according to the Children's Defense Fund, 34 percent of New York State children in families with incomes below the federal poverty line were not covered by either Medicaid or private health insurance.[5] **We recommend that New York State raise its Medicaid eligibility standard to 100% of the poverty level for all families and individuals.**

Enrollment: Even among those currently eligible for Medicaid, enrollment problems reduce the number actually receiving assistance and, in turn, the amount of aid coming to the clinics. Anecdotal evidence suggests that students (and their parents) who have family incomes low enough to qualify for assistance often are not enrolled for Medicaid. This is most likely to occur in families with sufficient income to place them close to the threshold, causing periodic lapses in eligibility. In other cases, families who are eligible do not know how to apply for Medicaid, or even that they are eligible, or are unwilling to endure the bureaucratic difficulty of the Medicaid enrollment process.

At present, the clinics lack an outreach capacity to enroll eligible students in Medicaid. Although current funding provides for an administrative function to be shared by the mid-level practitioner and the health aide, their workloads are already too large to permit taking on the specialized bureaucratic task of enrolling students (and their families) in Medicaid.

---

5. The Children's Defense Fund, The Data Book: The Nation, States and Cities, 1985, p. 23.

In some areas the amount of Medicaid reimbursement to be gained does not justify supporting staff time to check on and establish Medicaid eligibility. In other situations, however, such as that of New York City, where as many as one-half to three-quarters of a school's population may be eligible for Medicaid, clinics are losing a substantial amount of funding. **We recommend that a mechanism in the clinics for establishing eligibility and enrolling students in the Medicaid program be created and funded (either through state or federal funds) to assure that all students eligible to receive Medicaid in fact do so.**

In some cases, students are enrolled in Medicaid, but simply do not know their identification numbers. New York City's Medicaid Program has sent letters to all eligible teenagers notifying them of their eligibility and their identification numbers. While we think that the letters are an excellent idea for letting adolescents know where their particular needs can be met, we do not think these letters are adequate for identification purposes. **We recommend an identification card system for <u>all</u> New York State Medicaid recipients, such as that used in Maryland, where every individual has a computer identification card, permitting easy processing and verification of eligibility.**

Reimbursement: The existing school-based health clinics also have encountered problems with the reimbursement of services under federal and State Medicaid practices. In general, services that are preventive and routine (and therefore assumed to be covered under normal school health procedures) are not reimbursed.

The kinds of services not reimbursed under current practice include: psychosocial services **unless** provided by a psychiatrist, psychologist, or social worker; health education, either general or specific to the management of a chronic illness; parent and teacher conferences concerning students' health problems; screening tests when performed separately from a complete physical examination; or routine first aid treatment. These services can constitute approximately 30% of the care received by Medicaid-eligible students. Yet these are often the services that can be helpful in reducing the need for more expensive (and reimbursible) services. **We recommend that the State Department of Health and the Department of Social Services meet to establish reimbursement for a broader range of clinic services.**

Finally, the rate of reimbursement for clinic services that are covered is lower than that received by other kinds of medical facilities. This reflects two assumptions made when the clinics' rates initiallly were set. First, it was assumed that there would be little if any overhead expenditures because the clinics were located in schools. This seriously underestimated the amount of administrative work required to maintain the clinic. Second, it was assumed that the state grant would provide sufficient funds to cover whatever overhead costs were incurred. Because Medicaid reimbursements were so low, however, the state grant has been barely enough (if at all) to cover the expense of providing direct services to students.

Clearly, school-based health clinics have proven they can play a vital role in delivering health services to Medicaid-eligible students, many of whom are not now receiving the care they are entitled to under the Medicaid

program. To do so on a consistent basis, the clinics need better support from the Medicaid program. **We recommend that the Office of Medicaid Reimbursement (in the New York State Department of Health) set higher rates for services provided in school-based clinics, both to cover the real costs of providing these services, and to act as an incentive to the back-up providers to strenthen their commitment to the provision of preventive and primary health care services.**

The Child/Teen Health Plan: New York State's version of Medicaid's Early and Periodic Screening, Detection and Treatment Program (EPSDT), the Child/Teen Health Plan, provides a potential source of fiscal support for school-based clinics. Under the federal guidelines, EPSDT programs can, and indeed must, support outreach and case-management activities to make preventive health care services accessible to Medicaid-eligible children.[6] But the Child/Teen Health Program reaches a tiny fraction of these children--only 3.5% of school-age children actually received examinations in 1986. A significant problem in the delivery of services has been the difficulty reaching the child. This is due to the scarcity of EPSDT providers, the problem of poor parents' not placing sufficient importance on preventive care since they have not, in general, been able to afford it, and the passivity of New York State's outreach efforts to overcome this lack of knowledge.

---

6. In a recent judicial decision on the applicability of the federal EPSDT regulations in a lawsuit against New York City for failure to implement appropriate lead poison screening services, "the Fifth Circuit specifically found that Medicaid recipients have enforceable rights under the EPSDT program" granting the plaintiffs a "private right of action" against the city for its failure adequately to implement the law. New York City Coalition to End Lead Poisoning v. Koch, pp. 9-10.

School-based health clinics have proven an excellent potential outreach mechanism, bringing services to the child and, through health education and promotion activities, teaching children and families about the importance of preventive health care. Moreover, according to the Select Committee on Children, Youth and Families, children receiving EPSDT services have lower health costs than those children who do not.[7]

Maryland has used its EPSDT program's outreach and case management capacity to support a variety of innovative efforts to bring preventive services to poor children, spending $2 million in each of the last two years for these services alone. Two school-based health clinics, situated in high schools in low-income areas of Baltimore, were granted EPSDT support as an innovative approach to providing health services to adolescents, considered by Maryland to be a particularly difficult to reach population. Although EPSDT funds are not the sole support for the clinics, a substantial portion of their work is underwritten by these federal funds.

South Carolina, in 1986, increased its EPSDT utilization by almost 50% by sending public health nurses on home visits where children had not received services to which they were entitled. In its outreach plan for 1987, South Carolina has included school-based clinics as a recommended outreach mechanism for providing preventive care to Medicaid-enrolled children.

---

7. Cited in Children In Need: Investment Strategies for the Educationally Disdadvantaged, Committee for Economic Development, 1987, pp. 6,7.

We recommend that New York State's Department of Social Services, in collaboration with the New York State Department of Health, aggressively explore options for funding innovative outreach and case management approaches under the Child/Teen Health Plan, with school-based clinics as one possible approach. We further recommend that the New York State Legislature earmark a pool of additional Medicaid funds for such innovative outreach efforts.

Using such a funding pool, school-based health clinics might be supported in several ways:

- the first year of clinic operation can be underwritten as an outreach project, with a portion of funding for each year to be used for outreach to bring new students into the clinic;
- funding can be provided for a Medicaid eligibility worker to ensure that all Medicaid-eligible students are enrolled;
- funding can be provided for one session of health education concerning preventive health care for each eligible student;
- funding can be provided for that portion of outreach activities needed to reach the eligible student population;
- funding can be provided for complete physical examinations, as has been done in Newburgh on a contractual basis with the local social service district;
- funding can be provided for case management costs as a percentage of administrative costs;
- funds could be used to create a unit within the Department of Health or the Department of Social Services to oversee the disbursement of funds to special outreach projects.

Most of these strategies require the Child/Teen Health Plan to move away from its strict adherence to a "billable encounter" rubric for reimbursable services.[8] **This constraint is not federally mandated.**

---

8. This requires that all reimbursable services be provided to an indentifiable recipient in an indentifiable encounter with a service provider.

Considering the appallingly low utilization rates for Medicaid-enrolled children, we think new approaches to outreach and case management are amply justified.

Local Matching Funds

Some clinic projects in New York State have become fiscally self-sufficient after several years of operation. These cases are the exception, however, since most clinics are located in low-income areas that lack sufficient tax bases to generate support for a clinic. Most cities and localities, however, are able to make some contribution to the funding of school-based clinics from local revenues, once they are convinced of the value of the clinics' services. At no time, however, should the inadequacy of local resources be reason to deny the initiation of a clinic in a high-need area. **We therefore recommend that a state funding strategy, while initially providing most of the funds, encourage localities to move toward partial self-reliance over a five-year period.**

Other Federal and State Funds

A variety of federal and state funding streams also may provide support for school-based clinics, although their availability will vary depending on the location of the clinic. In addition, how the funds may be used to support clinic activities also will vary.

Direct support: Where funds are provided by either the state or federal government to pay for health care services for a specific target population, a clinic serving a substantial group of students from that population may be able to provide services to them on a contractual basis. This is the arrangement used in Newburgh, where the school-based clinic has

a contract from the local social services department to provide Child/Teen Health Plan examinations to Medicaid-enrolled students in Newburgh.

Indirect support: In some cases, a clinic may indirectly benefit from funding by collaborating with another agency (e.g. a social services agency where students might be referred for counseling services) to jointly hire a single staff person to work part-time for both. (In such cases, the staff member could be hired by one agency and "subcontracted" on a part-time basis to the clinic, or the clinic and the agency could informally agree to each hire the same person on a part-time basis.) This arrangement has the additional advantage of enhancing the linkage between the clinic and the outside agency.

Coordination of Services: In many cases, separate funding streams that support the provision of health-related services to school-age children lead to a patchwork rather than a pattern of services. Although strict regulations may prohibit the blending of funding streams, better coordination of services at the district and school-building level may amplify the range of services a clinic can provide, as well as enhance its relationship with the other support service providers in the host school and community.

Just how these varied funding streams can be used will be determined both by the source of funding and by the institutional authority which receives the funds. For example, in a large city school district, these funding streams may be received in different administrative divisions of the local school district: one in pupil personnel, another in health services, and yet another in substance abuse prevention services. But

these offices may be jointly administered in a small district, allowing for easier coordination, or even combination, of the resources.

What follows is a list of the major sources of funds that may be potential sources of support for school-based clinics in New York State.

Federal funds

The **Maternal and Child Health (MCH) Block Grant of the Public Health Services Act** was created in 1981, consolidating seven programs designed to serve children and pregnant women. Individual states have substantial latitude in setting eligibility criteria to govern the use of these funds within broad federal guidelines. In 1985, in the absence of an increase in state support for the School Health Demonstration Program, the New York State Department of Health used MCH funds to create the nine high school-level clinics in New York City. Although the state has the option to commit more MCH funds to school-based clinics, the Commissioner of Health has indicated that further use of these funds, if at all, will only follow a clear and broad commitment of legislative support for school-based health clinics.

Section 330 of the Public Health Services Act created a framework for grants to community health centers in areas designated by the federal government as "medically underserved." Although most of these funds are used to support comprehensive community health facilities, nearly 20% of these facilities operate satellite clinics in areas "where the greatest access to underserved people and the greatest impact can be attained."[9]

---

9. E.M. Hadley, S.R. Lovick, D. Kirby, op. cit., p. 53.

In Jackson, Mississippi, a community health center provides services to students in seven schools, relying heavily on Section 330 funds.

Although the Community Health Center funds were cut in 1982, resulting in the closing of more than 250 centers around the country, the fiscal year 1988 budget contains a $750 million increase in health care funding, including unspecified funding increases for both maternal and child health programs and community health centers.

Under **Title X (Family Planning and Population Research Act)**, the provision of federally-funded family planning services to adolescents was mandated in 1978. By 1981, more than one-third of the 3.8 million individuals served under this legislation were 19 years old or less.[10]

Unfortunately, Title X family planning funds already are stretched thin, and direct support of school-based clinics may not be possible. In some areas, however, school-based clinics and Title X projects may be able to collaborate, with the family planning clinics providing in-kind services in family planning counseling, education, and in-school outreach activities. (At the time of writing, future use of these funds has been stalled by restrictions proposed by the Reagan Administration).

Finally, the **Adolescent Family Life Act of 1981, Title XX of the Public Health Services Act**, provides funds for activities aimed at the prevention of adolescent pregnancy and at providing services to pregnant and parenting adolescents. This legislation has been mired in the

---

5. S. Bailey and R. Price, Family Planning, Congressional Research Service White Paper, Library of Congress, April 1982, in Washington Report, Society for Research in Child Development newsletter, October 1984, p. 3.

controversy concerning the Reagan Administration's approach to adolescent pregnancy prevention. Emphasis has been placed on the promotion of premarital sexual abstinence, and funds may not be used for any abortion-related activities. While this certainly limits the potential use of Title XX funds for family planning activities, those clinics serving substantial numbers of pregnant and parenting adolescents may be able to obtain support for prenatal care and counseling activities.

State Funding Sources

The second major source of state funds potentially available to support school-based clinics (after the School Health Demonstration Program) is provided under state **public health programs**, supported both by federal block grant and state tax-levy resources. In 1987, New York State increased its contribution to match local county and municipal public health expenditures from $ .33 to $ .40 per dollar and began drafting regulations concerning how these additional funds should be spent. One provision under consideration is the requirement that any public health funds spent on school health services must be used to implement the primary care model of the School Health Demonstration Project. In medically underserved areas, where local public health departments may be the principal provider of primary and preventive care to poor and uninsured individuals, such a provision would enable local public health departments to establish or support school-based health clinics.

Several categorical health programs, although not specifically targeted to school-age children, and in some cases with only minimal funding commitments at the present time, may provide a rubric under which to seek additional support for school-based clinics. New York State's

Primary Care Initiative seeks to ensure the continued availability of basic primary health care resources to underserved populations and/or designated areas of geographic need, and may prove a source of support for clinics that meet these criteria. The initiative was stimulated in part as an attempt to compensate for cuts in federal Section 330 funds that had supported a network of community health centers. Under the initiative, grants may be made: 1) to fund deficits attributable to providing comprehensive care to a medically indigent population; 2) to support primary health care providers in designated areas who are threatened with severe financial difficulties; 3) to introduce or expand primary care service in underserved communities; and 4) to enhance primary care services for medically indigent populations.

The **Rural Health Network Demonstration Program** is designed to support demonstration projects to improve the delivery of rural health services and the development of cooperative service networks. Although only minimally funded at this time despite the growing severity of rural health problems, this program might be tapped as a source of start-up funding for clinics in rural school districts.

The **Adolescent Pregnancy and Parenting Services Program**, coordinated by the New York State Council on Children and Families and administered by the New York State Department of Social Services, assists pregnant, parenting, and at-risk teenagers through grants to community consortia composed of local organizations providing coordinated health and social services to the target population. Community consortia, as part of their applications for funds, can request support for school-based health clinics.

The **New York State Family Planning Program** supports family planning clinics throughout the state. In addition to a range of reproductive health care services, many of these community-based clinics focus on the special needs of adolescents. In instances where community sentiment will not support the provision of reproductive health care within a school-based clinic, coordination with the family planning clinics becomes an essential linkage in meeting the health care needs of an adolescent population. In addition, where possible, collaborative arrangements may be established to allow personnel from a community family planning clinic to assist the school-based clinic in performing outreach and health education activities.

Funding for Health-Related Activities in Schools

Although school health services per se are not supported by State funds in most districts, the State does provide funds for health-related activities under a number of programs, some of which originate at the federal level. Most such programs are aimed at prevention--of pregnancy, alcoholism, substance abuse, and school dropout. Many, if not all, suffer from inadequate levels of funding and a lack of coordination with other related activies. **We recommend that a concerted effort be made to coordinate the counseling and health education services provided under these funded programs with the work of the clinics, particularly at the adolescent level.**

The new **Comprehensive Health Education Demonstration Program** provides support on a competitive grant basis to local efforts to address health education issues in an innovative and comprehensive manner. Where school-based clinic health educators are part of such an approach, a portion of

the funding may provide at least temporary support for the health education component of the clinic's work.

Through the federal government, schools receive **drug prevention funds**, administered through the Department of Substance Abuse Services. Although the current year's local assistance allocation of approximately $7 million has been delayed over disagreements in the regulations drafted by the state, these funds will eventually support services to young people considered at high risk of becoming drug abusers. Current drug programs in schools often have operated completely apart from other health and guidance services. In a school with a clinic, however, drug and alcohol abuse prevention programs should be coordinated with anticipatory guidance activities conducted by clinic staff.

The **Attendance Improvement/Dropout Prevention (AIDP) Program** ($37 million) and the new **Rural Dropout Prevention Program** ($1 million) both include language that enables local districts to provide health and counseling services to students where appropriate to increase school attendance and graduation rates. In most school districts eligible to receive assistance (many of which also have higher proportions of medically underserved children than elsewhere), counseling services are provided through the guidance and pupil personnel departments rather than under the auspices of the school health office. State Education Department officials, however, are concerned with the lack of coordination between AIDP funds and other related programs and should be amenable to collaboration between school-based clinics and AIDP counseling staff designed to limit the considerable likelihood that one student may receive different (and even conflicting) services from both sources.

In 1987, the Legislature appropriated $7 million for a **Youth At-Risk Initiative**, at least in part to coordinate the services provided under other categorical programs aimed at preventing a range of problems. The activities specifically mandated in the legislation address the prevention of adolescent pregnancy and sexually-transmitted diseases, including the implementation of a case management approach. "Preventive health services" are listed as eligible activities for funding.

The **Educationally Related Support Services Aid (ERSSA)** program provides funds for counseling services for students experiencing emotional difficulties in an attempt to prevent their referral and placement in special education programs. While in large urban districts like New York City the personnel delivering these preventive counseling services may be specifically assigned to special education in smaller districts, these funds may provide partial support for counseling services delivered under the auspices of, or in cordination with, the clinic to meet the requirements of the legislation.

The new **Pupils with Compensatory Educational Needs (PCEN)** program is designed to supplement the existing PSEN program. Funded at $35 million, it may provide some support for health and health-related services in districts where these services are viewed as essential to help students learn in school.

The **Primary Mental Health Project**, now funded at $400,000, is a replication of an extremely successful project to provide training to "child aides" to help students experiencing emotional difficulties

adjust to school. Although currently a small program, the model is likely to be incorporated into forthcoming State Education Department recommendations on approaches to enhancing school completion and funded at a higher level. Services provided under this program may be coordinated with clinic services at the elementary school level when clinic staff note that the genesis of students' health problems originates in difficulty adjusting to the school context.

Few of the funding streams in education are likely to yield direct financial support for school-based health clinics, but all provide the kinds of services that address some of the same health needs that the clinics try to meet. Often these programs support staff whose services would otherwise not be available through the clinics. Frequently, however, the services provided by these problem-oriented categorical programs operate in isolation from one another. This produces a fragmentation and duplication of services in high-risk schools that often allows students to fall through the cracks between programs. **We emphatically recommend that these multiple and valuable sources of assistance be coordinated with the work of the school-based clinics, which have the capacity to case manage the health and health-related services needed by any given student.**

Each local school district, as part of its planning for a school-based clinic, should explore all the potential sources of revenue for the clinic program and develop a long-term plan for securing support for the clinic's services.

References

American Academy of Pediatrics. "American Academy of Pediatrics Guidelines: School-Based Health Clinics." March 4, 1987.

American Academy of Pediatrics. "State Medicaid Report: New York State." Office of State Advocacy. 1987.

American Academy of Pediatrics. "Trends in Pediatrician Participation in State Medicaid Programs." January 1985.

American Medical Association. "White Paper on Adolescent Health." 1986.

Bailey, S. and R. Price. Family Planning. Congressional Research Service White Paper. Library of Congress. April 1982.

Blendon, R.J., L.H. Aiken, H.B. Breemean, B.L. Kirkman-Liff, and J.W. Murphy. "Uncompensated Care by Hospitals or Public Insurance for the Poor: Does it Make a Difference?" The New England Journal of Medicine. May 1, 1986.

Bronx Committee for the Community's Health. "A Report on Medical Indigency with Special Focus on the Bronx." March 1987.

Children's Defense Fund. "Adolescent Pregnancy: An Anatomy of a Social Problem in Search of Comprehensive Solutions." January 1987.

Children's Defense Fund. "Building Health Programs for Teenagers." May 1986.

Children's Defense Fund. The Data Book: The Nation, States and Cities. 1985.

Cohen, M.I. "Importance, Implementation, and Impact of the Adolescent Medicine Components of the Report of the Task Force on Pediatric Education." Journal of Adolescent Health Care. 1980.

Cuomo, Mario. State of the State Message 1987.

Dempsey, R. "The Trauma of Adolescent Suicide." National Association of Secondary School Principals. 1987.

Dutton, D.D. "Children's Health Care: The Myth of Equal Access." Better Health for Our Children: A National Survey. Report of the Select Panel for the Promotion of Child Health to the U.S. Congress and the Secretary of Health and Human Services, Volume IV. 1981.

EBRI News. "11 Million Children Have No Health Insurance." March 1987.

Education Week. "Health" column. April 15, 1987, p. 7.

Family Life Matters. "Reaching Adolescents: An Interview with Dr. Robert L. Johnson." Summer 1987. (A publication of the New Jersey Network for Family Life Education).

Hadley, E.M., S.R. Lovick and D. Kirby. School-Based Health Clinics: A Guide to Implementing Programs. Washington: Center for Population Options. 1986.

Hall, E. and W. Marcus. "A Paper on Developing a Workable State-Local Public-Private Partnership System of Rural Health Services." November 1985.

Irwin, C. "Why Adolescent Medicine?" Journal of Adolescent Health Care. November 1986.

Kasper, J.D. "Children At Risk: The Uninsured and the Inadequately Insured." Annual Meeting of the American Public Health Association. Maternal and Child Health Section. September 1986.

Kirby, D. with S. Lovick, J. Levin-Epstein, and E. Hadley. "School-Based Health Clinics: An Emerging Approach of Improving Adolescent Health and Addressing Teenage Pregnancy." Washington: Center for Population Options, April 1985.

Marks, A., J. Malizio, J. Hoch, R. Brody, and M. Fisher. "Assessment of Health Needs and Willingness to Utilize Health Care Resources of Adolescents in a Suburban Population." Journal of Pediatrics. March 1983.

McManus, M.A. and S.M. Davidson. "The Role of Public Health Insurance for Children." Washington, D.C.: McManus Health Policy Associates, 1986 (Draft).

Mundinger, M. "Health Service Funding Cuts and the Declining Health of the Poor." New England Journal of Medicine. July 1985.

New York City Coalition to End Lead Poisoning v. Koch.

New York State Legislative Commission on Rural Resources. "Overall Tasks and Background Information for Participants." Rural Health Symposium. April 29-May 1, 1987.

New York Statewide Health Coordinating Council and New York State Department of Health, Division of Planning, Policy and Resource Development. "Proposed State Health Plan, 1986." Volume 1. Data from the New York State Department of Health. Vital Statistics. 1984.

Perry, D.F. "A Paper on Issues in Rural Health Care Delivery." Legislative Workshop, "Toward a Rural Health Care Policy." November 1985.

Pirani, S. Rx for Schoolchildren. Citizens' Committee for Children. 1983.

Robert Wood Johnson Foundation. Special Report on the National School Health Services Program, Number One. 1985.

Rosenbaum, S. and K. Johnson. "Providing Health Care for Low-Income Children: Reconciling Child Health Goals with Child Health Financing Realities." The Milbank Quarterly, Volume 64, Number 3. 1986.

Rosenbaum, S. Testimony before the Select Committee on Children, Youth and Families. March 23, 1987.

School Health Digest. January-February 1981.

Signalhealth. "New York's Poor: A Growing Problem." State Emergency Network Social and Economic Security Counterbudget Report (SENSES). January 1987.

Signalhealth. "New Yorkers are Losing Their Health Insurance." SENSES. March 1986.

Slap, G.B. "Adolescent Medicine: Attitudes and Skills of Pediatric and Medical Residents." Pediatrics, Volume 73. 1983.

Sulvetta, M.B. and K. Swartz. "The Uninsured and Uncompensated Care: A Chartbook." National Health Policy Forum. June 1986.

Weitzman, B. "Getting Care: Poor Children and New York City Hospitals." United Hospital Fund of New York. April 1987.

Welfare Research, Inc. (Funded by the New York State Department of Health):

"Health Services for High School Students: Assessment of the New York City (High) School-Based Clinics." June 1987;

"Evaluation of the New York State School Health Demonstration Program: Final Report." September 1986;

"Evaluation of the Impact of the New York State School Health Demonstration Project on School Attendance." 1984;

"Evaluation of the New York State School Health Demonstration Program. September 1983 - June 1984." 1984;

"Findings of the School Health Demonstration Project Teacher Survey." July 1983;

"Findings of the School Health Demonstration Project Principals Survey." September 1983;

"Evaluation of the New York State School Health Demonstration Program, September 1982 - June 1983."

Youth 2000: Imperatives for Action. "Child and Adolescent Health Profile." Selected New York State data compiled for conference, April 27-28, 1987.